DOCUMENT RESUME

ED 259 844 PS 015 240

TITLE	Who Cares for Kids?
INSTITUTION	League of Women Voters of Illinois Education Fund, Chicago.
SPONS AGENCY	Washington National Insurance Co., Evanston, IL.
PUB DATE	85
NOTE	27p.
AVAILABLE FROM	The League of Women Voters of Illinois Education Fund, 67 East Madison Street, Chicago, IL 60603 ($1.50, plus $1.00 shipping).
PUB TYPE	Viewpoints (120) -- Reports - Descriptive (141)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Child Abuse; Child Neglect; *Child Welfare; *Day Care; *Disabilities; Drug Abuse; Early Childhood Education; Early Parenthood; Emotional Disturbances; Justice; *Juvenile Courts; *Mental Health; Pregnant Students; Special Education; State Agencies
IDENTIFIERS	*Child Support; Illinois; Permanency Planning (Foster Care)

ABSTRACT

This collection of 12 educational bulletins provides background information on highly visible, "hot" issues receiving public attention. After four pages of information concerning the current state of children's services in Illinois, two-page discussions are provided of 11 general topics. Titles in the collection are (1) "Overview of Services"; (2) "Child Abuse and Neglect: Missing Children"; (3) "Child Support"; (4) "Day Care and Early Childhood Education"; (5) "Drug and Alcohol Abuse"; (6) "Education for Special Needs: Truancy, Vocational Education"; (7) "Health Care: Physical and Developmental Disabilities"; (8) "The Juvenile Court"; (9) "Juvenile Justice: Courts and Corrections"; (10) "Mental Health and Emotionally Disturbed Children"; (11) "Permanency Planning: Reunification, Foster Care and Adoption"; and (12) "Teenage Pregnancy and Parenthood." Referral sources are listed at the end of each discussion. In addition to discussing the issues, contents generally describe funding arrangements and existing programs addressing problems. (RH)

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Who Cares for Kids?
OVERVIEW OF SERVICES

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LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

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Issues such as child abuse, missing children, and foster care are but a few of the visible issues identified by the child welfare system today. Although these hot issues are receiving public attention, there are other ongoing issues and trends evident within the system of services available to children and youth in Illinois.

To provide Illinois citizens with a background from which to view the current state of children's services, the League of Women Voters of Illinois has identified some of the issues around which agreement, discussion or controversy have gathered.

League interest dates back to the presidency of Julia Lathrop, a former League president and one of the founders of the 1899 Family Court Act. League has maintained a continuing concern about the welfare of children. An in-depth study in Illinois was undertaken in 1963. Since that time, League designed and participated in the Illinois Juvenile Court Watching Project, the first of its kind in the country. League further broadened its knowledge and participation during the past several years as a result of a site visitation project to over 70 facilities housing juveniles, including county jails, detention homes, shelters, juvenile correctional facilities and private residential facilities.

HISTORICAL PERSPECTIVE

During the 19th century the general theory was that children in need could best be helped by removing them from home, and that when death or desertion left children stranded, they could more economically be served in a group setting. Generally the efforts of both public and private agencies during this period were toward removing the child from home rather than providing services designed to keep the family intact, whether the removal was necessitated because the child had committed a delinquent act, was an orphan, was handicapped or was otherwise dependent. In those days child abuse as a subject of public interest was unheard of. The first Illinois child abuse legislation was passed in 1965.

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Children with special needs were placed with adults in the Asylum for Deaf and Dumb (1839), School for the Blind (1849) and School for the Feeble-Minded (1865). The Chicago Reform School operated until it burned in the Great Fire of 1871. The Illinois State Reformatory at Pontiac housed 500 delinquent boys by 1888. Many children who became dependent upon the state found themselves in county almshouses or jails. In 1890 it was reported that thirteen percent of the population of county almshouses were children.

The separation of dependent and delinquent children from the adult poor, handicapped or criminal evolved slowly. Although placement of minors in prison was limited as early as 1833, removal of juveniles from jails, which began with the passage of the County Detention Home Act of 1907, is not complete today. Young people continued to be cared for with adults in mental health wards until 1969.

With the passage of the Family Court Act in 1899, Illinois established the first juvenile court in the world, reflecting the philosophy that children in trouble should be treated "not as criminals, but as children in need of aid, encouragement and guidance." The court was to act as a wise parent (in loco parentis) to see that a child received proper care, if not in his/her own home, then in another permanent home as a family member, by adoption whenever possible. The act also authorized the appointment of probation officers who were to provide advice and assistance to juveniles in the community.

The Funds to Parents Program, otherwise known as the Mother's Pension, was inaugurated in 1911 to provide financial assistance to children in fatherless homes and was financed by counties. In 1917 the state set up a Division of Child Welfare to provide parole services to youngsters coming out of state institutions or to find foster homes for dependent and neglected children. Children's homes, detention homes and other small institutions serving children in their own geographic areas were developed by some counties and municipalities.

As services have evolved over the years, so have the structures through which they are offered. Most of the state code departments serving children came into being during a single decade: the Department of Mental Health & Developmental Disabilities (DMH/DD) was created in 1961, Department of Children & Family Services (DCFS) and the Department of Public Aid (DPA) in 1963 and the Department of Corrections (DOC) in 1970. Legislation passed during that period set the framework for much of the current service network for children: the Juvenile Court Act of 1965, the Child Care Act, the Abused and Neglected Child Reporting Act, the Unified Code of Corrections, the School Code and the Mental Health and Developmental Disabilities Code, which for the first time made specific reference to minors.

Many programs were initiated through federal funding: Aid to Families with Dependent Children, which began with Social Security legislation in 1935, the Education for all Handicapped Children Act (PL 94-142) in 1975, the Adoption Assistance and Child Care Act (PL 96-272) in 1980, Federal Day Care Requirements of 1968 and the Juvenile Justice and Delinquency Prevention Act of 1974.

The recent shift from categorical funding (single-issue services) to block grants (general group services) has given state agencies and local communities more discretion as to how services will be provided within specific federal guidelines and has placed renewed emphasis on planning. Cutbacks in federal spending for social services makes coordination of service provision essential in order to achieve maximum effectiveness.

ILLINOIS STATE AGENCIES SERVING CHILDREN

Major services to children are provided through the following state agencies:

The Department of Alcoholism & Substance Abuse (DASA) was created by the General Assembly in 1983. It consolidates functions previously carried out by the Division of Alcoholism of the Department of Mental Health & Developmental Disabilities and by the Dangerous Drugs Commission. DASA administeres funds from the federal Alcohol, Drug Abuse and Mental Health Block Grant and the Social Services Block Grant. DASA funds and monitors alcoholism treatment and drug programs and is the licensing agency for drug programs. An important part of the Department's responsibility is the planning, coordination and funding of community-based prevention programs, especially for youth and other groups at risk of developing substance abuse problems.

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The Department of Children & Family Services (DCFS) has a wide range of responsibilities for child welfare services. DCFS investigates suspected cases of child abuse and neglect. It is the regulatory agency for all licensed child care facilities, both residential and day care. DCFS may provide or contract for such services as counseling and homemaker services to families, substitute care for children who cannot stay with their parents, help to unwed parents and adoption services. At present DCFS operates emergency shelter care residences in the Chicago area. DCFS administers a grant program through its Division of Youth and Community Services to encourage development of community-based service networks to divert adolescents from involvement in the child welfare or juvenile justice sytems.

The Department of Commerce & Community Affairs (DCAA) has, as a small part of its overall responsibility, the administration of the Job Training Partnership Act (JTPA) which replaced the Comprehensive Employment and Training Act (CETA). JTPA provides job training for the economically disadvantaged and dislocated workers. Forty percent of JTPA funds must be used for youth.

The Department of Corrections (DOC) provides for the care, custody, treatment and rehabilitation of juveniles in a division separate from adult services. DOC evaluates all juveniles committed by the courts for assignment to an appropriate facility or program, operates residential facilities, provides educational, vocational and other services and supervises juveniles after release to the community. DOC is the regulatory agency for local lockups, jails and detention homes.

The Department of Mental Health & Developmental Disabilities (DMH/DD) serves the mentally ill and the developmentally disabled. DMH/DD operates residential mental health centers on a regional basis, purchases psychiatric hospitalization and other care, assists parents with placement of their children through individual care grants and operates three training institutes. One, the Institute for Juvenile Research, is also responsible for the Department's child and adolescent services.

The Department of Public Aid (DPA) assumed county welfare functions when it was formed in 1963. DPA administers the federal Aid to Families with Dependent Children (AFDC) program, the Medical Assistance Program, the USDA Food Stamp Program and the Social Services Block Grants. DPA has responsibility for determining eligibility under many federal programs, for child support enforcement and provides social services to groups such as victims of domestic violence. The Department also administers General Assistance for Chicago and receiving units which occasionally include children.

The Department of Public Health (DPH) is responsible for programs and regulations that foster better health care. DPH is the licensing agency for medical facilities, alcoholism programs and long term care facilities for persons under twenty-two. DPH administers the federal Maternal and Child Health Block Grant, Preventive Health and Health Services Block Grant and the Special Supplemental Food Program for Women, Infants and Children (WIC). DPH coordinates perinatal programs for high risk mothers and infants, genetic counseling, tests for all newborns, immunizations and adolescent family planning programs. DPH maintains all vital records, is responsible for coordiantion of health planning and provides basic health grants to municipal and county health departments.

The Department of Rehabilitation Services (DORS), established in 1979, is responsible for providing services to blind, deaf and orthopedically impaired children and adolescents who cannot be served by the public schools. DORS operates the School for the Visually Impaired, the School for the Deaf and the Children's School and Rehabilitation Center for these children.

Education is the major service that reaches almost every child and represents the largest outlay for children in the state's budget. The **Illinois State Board of Education** (ISBE) was created by the 1970 Constitution. Its 17-member board, named by the Governor, appoints the State Superintendent of Education. ISBE is responsible for setting the educational policies and guidelines for elementary and secondary schools, including bilingual, vocational, gifted, adult and special education programs. The board also recommends modification in the School Code to the General Assembly and suggests a budget for state aid to local school districts. The state is divided into Educational Service Regions, each headed by an elected regional superintendent of schools. This superintendent supervises the local school districts within the county or region and acts as the agent of the state.

Administrative Office of the Illinois Courts (AOIC) was created by the 1970 Constitution to assist the Chief Justice in administering and supervising the Illinois court system. It is responsible for standards for recruitment, evaluation and training of court personnel, financial administration of the court system, continuing education for judges and non-judiciary personnel, uniform record and information systems, statistical compilation and research. Subsidies and grants to local probation departments are administered through the Probation Division.

Local Government Units — counties, townships, municipalities and special districts—also provide services to children and their families. For example, counties in Illinois provide probation services for juveniles and may provide health services. Other examples of local services are youth and mental health programs, day care, recreation and libraries. Public schools are governed by locally elected school boards and funded through local property tax levies, supplemented by state and federal funds. Funding for other local programs may be a mix of tax levies and general funds, federal and state funds, fees and contributions from the private sector.

The voluntary sector is also a major pariticpant in providing children's services. A public/private partnership and/or purchase of service by a public agency from a private provider is one way of expanding the dollars available for service. As an example, DCFS frequently purchases such services as day care, foster care, adoption and residential treatment from private agencies. State funds are then augmented by the voluntary agency, usually through contributions from private individuals, churches, United Way and grants.

CONCLUSIONS

Services for Illinois children and youth remain in a state of flux. In spite of the current hot issues and media attention paid to certain issues, on-going concerns and trends remain visible. Shrinking federal dollars in terms of human services have impacted services to children. Fewer dollars, plus a lack of planning at the federal and state level, prevent coordination and cooperation between public and private agencies in their delivery of many services to children at all levels. Also, in times of fiscal constraints, the adult service system often preempts children's services when the service systems are not delineated. Therefore, gaps in services are evident and often more services exist at the crisis care end of the system rather than at the front end with prevention services. In Illinois the current trend is toward crisis intervention at the community level. Deinstitutionalization resulting from both federal and

state thrusts is pushing the creation of more community based services. If more community services are available, the hope is that services can intervene in troubled youths' lives before more costly crisis services, such as institutionalization, are necessary. The need to deal with the whole child also raises concerns regarding needed cooperation and coordination often missing in provision of services. Joint agency service provision is necessary for intervention in the multi-problem child's life. The individual plan mandated by both special education and permanency planning legislation are major efforts to put in place services for the whole child. Another concern is the quality of services which needs to be safeguarded by maintenance of standards. A final concern is citizen access to services. Many governmental bodies are required to issue annual reports. Most state agencies have an information officer; governmental bodies are required to designate a staff member to handle requests under the Freedom of Information Act. However, a visible state advocacy group for children, the Illinois Commission on Children, is now defunct. With its recent demise arises the concern for citizen access to the system of children's services at the state level.

Children's services will probably always remain in a state of flux. Issues such as the ones discussed here will probably never be completely solved or laid to rest. The League of Women Voters of Illinois Education Fund has provided this publication to give Illinois citizens background information so that they can better evaluate the current services provided for children and thus participate in the creation of a positive climate to help prepare Illinois children and youth for the twenty-first century.

REFERRAL SOURCES - State Agencies

Department of Alcoholism & Substance Abuse
100 E. Washington St.
Springfield, Ill. 62706
217-782-0685
Chicago: 100 W. Randolph St.
Chicago, Ill. 60601
312-793-9500

Department of Children & Family Services
1 North Old State Capitol Plaza
Springfield, Ill. 62706
217-785-2509
Chicago: 100 W. Randolph St.
Chicago, Ill. 60601
312-793-6800

Department of Commerce & Community Affairs
620 E. Adams St., Third Floor
Springfield, Ill. 62701
217-785-1032
Chicago: 310 S. Michigan
Chicago, Ill. 60604
800-252-2923

Department of Corrections
1301 Concordia St.
Springfield, Ill. 62706
217-522-2666
Chicago: 100 W. Randolph
Chicago, Ill. 60601
312-793-3017
Juvenile Parole: 312-793-2970

Department of Law Enforcement
Room 103, State Armory Building
Springfield, Ill. 62706
217-782-7263
Chicago: 100 W. Randolph
Chicago, Ill. 60601
312-793-3826

Department of Mental Health & Developmental Disabilities
Room 401, Stratton Bldg.
Springfield, Ill. 62706
217-782-2243
Chicago: 100 W. Randolph
Chicago, Ill. 60601
312-793-2735

Department of Public Aid
316 S. Second St.
Springfield, Ill. 62762
217-782-6716
Chicago: toll-free number
800-252-8635

Department of Public Health
535 W. Jefferson, Fourth Floor
Springfield, Ill. 62701
217-782-4977
Chicago: 100 W. Randolph
Chicago, Ill. 60601
312-793-2793

Department of Rehabilitation Services
623 E. Adams
Springfield, Ill. 62705
217-785-0218
Chicago: 100 W. Randolph
Chicago, 60601
312-793-2934

Developmental Disabilities Protection & Advocacy Board
180 N. LaSalle
Chicago, Ill. 60601
312-397-3536

Governors Office of Interagency Cooperation
312-793-2754

General Information for State Agencies
Springfield: 217-782-2000
Chicago: 312-793-3500

Governor's Planning Council on Developmental Disabilities
840 S. Spring St., Second Floor
Springfield, Ill. 62706
217-782-9697

Guardianship & Advocacy Commission
305 Stratton Bldg.
Springfield, Ill. 62706
217-785-1540
Chicago: 123 W. Madison
Chicago, Ill. 60603
312-793-5900

State Board of Education
Room S466
100 N. First St.
Springfield, Ill. 62777
217-782-4321
Chicago: 188 W. Randolph
Chicago, Ill. 60601
312-793-2220

REFERRAL SOURCES - Organizations and Hotlines

Adoption Information Center of Illinois
800-572-2390

Association for Retarded Citizens
312-922-6932

Child Abuse Hotline (Dept. of Children & Family Services)
800-252-23873

Child Care Association of Illinois
217-528-4409

Cocaine Hotline
800-COCAINE

Coordinating Council for Handicapped Children
312-939-3513

Day Care Action Council of Illinois
312-561-7900

Day Care Connection
312-348-WORK

Illinois Action for Foster Childre
312-579-0179

Illinois Alcoholism and Drug Dependence Association
800-252-6301

Illinois Association for Citizens with Learning Disabilities
312-663-9535

Illinois Caucus on Teenage Pregnancy
312-621-0023

Illinois Coalition for Permanent Families For Children
312-392-9255

Illinois Collaboration on Youth
800-252-8045

Illinois Foster Parents Association
217-673-6021

Illinois Health Care Association
217-528-6455

Illinois Public Health Association
217-522-5687

Illinois Task Force on Child Support
312-341-0013

Juvenile Protection Association
440-1203 (24 hrs.)

League of Women Voters Legislative Hotline
800-252-8959

National Center for Missing and Exploited Children
800-843-5678

National Runaway Switchboard
800-621-4000

Office of Advocacy Services, Dept. of Corrections
815-726-6114

Office of the Lieutenant Governor - Drug Abuse Hotline
800-252-6584

Parents Anonymous (National)
800-421-0353

Parents Too Soon Hotline
800-572-3270

University of Illinois, Division of Services to Crippled Children
1919 W. Taylor
Chicago, Illinois
312-996-3550

REFERENCES

Standards for the Administration of Juvenile Justice. Washington: Report of the National Advisory Committee for Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, 1980.

Children Without Homes: An examination of public responsibility to children in out-of-home care. Washington: Children's Defense Fund, 1976.

Doctors and Dollars are not Enough. Washington: Children's Defense Fund, 1976.

Knitzer, Jane. *Unclaimed Children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington: Children's Defense Fund, 1982.

Testa, Mark. *The State of the Child*. Chicago: The Children's Policy Research Project, The University of Chicago, 1980.

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Investment in an Independent Future: An agenda for children and youth. Chicago: Final Report of Governor Thompson's Task Force on Children, 1983.

Report of the Committee on Access to Health Services. Springfield: Illinois Commission on Children, 1984.

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ACKNOWLEDGEMENTS

"Who Cares for Kids?" was researched and written by members of the League of Women Voters of Illinois Child Welfare/Juvenile Justice Committee, under the direction of Peg Matthias, Chair.

This publication was funded by grants from Sahara Coal Company, GATX Corporation, Washington National Insurance Company, Allstate Foundation and Harris Foundation.

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Who Cares for Kids?
CHILD ABUSE & NEGLECT
Missing Children

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

Reports of child abuse and neglect in Illinois have risen from 719 in 1971 to more than 66,000 in 1984. Part of the increase is due to improved reporting and increased public awareness of the problem. The economic situation of the past few years has also meant greater stresses on many families, sometimes to child abuse and neglect. It is impossible to determine how much neglect and abuse is unreported. Child welfare workers believe that only a small portion of actual cases are ever revealed. In FY 84* the number of cases of neglect in Illinois were almost double those of abuse, yet neglect is often overshadowed by concern about abuse, particularly sexual abuse. That concern is reflected in measures such as programs for victims of domestic violence, hotlines for missing children and criminal background checks of persons who work with children.

CHILD ABUSE & NEGLECT

According to the Abused and Neglected Child Reporting Act (ANCRA), a neglected minor is defined as someone under the age of 18 who is not provided with adequate support, education, medical or other care necessary to the minor's well being (including adequate food, clothing and shelter) or who is abandoned. An abused minor is someone under 18 who is physically abused, sexually abused, tortured or given excessive corporal punishment or one who is in substantial danger of physical injury. A parent or immediate family member, any person responsible for a child's welfare, any individual residing in the same home as the child or a paramour of the child's parent can be charged with abuse or neglect under the Abused and Neglected Child Reporting Act. Many instances of prostitution or sexual abuse do not fall under the Act. The state's attorney has the authority to prosecute a parent or any other person under criminal proceedings.

The Department of Children & Family Services (DCFS) is the state agency mandated under the ANCRA to investigate suspected cases of child abuse and neglect and to provide services to the victims of abuse and neglect and their families. A single statewide toll-free hotline number, 800-252-2873, is reserved for reporting suspected cases of abuse and neglect.

When a call is received, staff at the State Central Register (SCR) determines whether the report falls within the responsibility of DCFS. If the alleged perpetrator is not a person as described in the ANCRA (a parent, family member, caretaker, etc.) the caller is told to contact a local law enforcement agency. Under formal agreements between DCFS and the police departments of Chicago, East St. Louis and Quincy, such calls are automatically reported to those police departments by the SCR.

If the alleged perpetrator is a person as described in the ANCRA, staff check to determine whether prior reports on either the child or the perpetrator exist. The report is also entered on the child abuse and neglect tracking system (CANTS), the computerized system that monitors progress on DCFS investigations of reports of abuse and neglect. The 63,432 reports in 1983 were only the cases reported to DCFS. The number reported to law enforcement agencies is unknown.

If an investigation by DCFS is warranted, it must begin within 24 hours of receipt of a report. Each DCFS region has at least two investigating teams, usually with one staff member experienced in criminal investigations, a nurse and a specially trained social worker. Primary goals are to assure the safety of the child and to determine the validity of the allegations. The child may be taken into protective custody. For example, a juvenile court may order a hospitalized child discharged to substitute care, rather than returned to the abusing parent, pending investigation and services to the family.

The investigating team reports either that the report is "indicated," meaning that there is credible evidence of the alleged abuse or neglect or, in the absence of such evidence, that the report is "unfounded," or, if the investigation cannot be completed on the basis of information provided, that the report is "undetermined." The investigation must be completed within 60 days but may be extended for good cause. If abuse or neglect is indicated, follow-up services may be needed, such as counseling, homemaker services, emergency caretaker services, protective day care, parenting education, foster or residential care and case management. DCFS may provide these through its own resources and staff or through purchase of care from private agencies. If a family refuses to cooperate, DCFS may file a petition in juvenile court asking that the child be found neglected or abused and made a ward of the court so that services could be provided. When it is believed that a child should not be returned to the parents, DCFS may request the juvenile court to terminate parental rights, thus freeing the child for adoption.

Under state's original Abused Child Act, physicians, dentists and hospital personnel having responsible cause to believe a child had been abused or neglected were required to report the case. Later amendments added school personnel, social workers and administrators, nurses, nursery school and day care personnel, law enforcement officers and field personnel of several state agencies to those required to report. Persons who report in good faith are immune from legal consequences.

IN FY 1984 the State Central Register received reports involving 67,058 children. Credible evidence of abuse or neglect was indicated in reports on 29,558 children: 88 deaths, 54 due to abuse/neglect; 5,486 reports of sexual abuse 3,252 were indicated; physical abuse was indicated in 7,224 of 19,397 reports and neglect in 19,028 of 42,087 reports.* Approximately one-fourt of the children involved were under two years of age, another 20 percent were 3 to 5, 23 percent were 6 to 9 and 13 percent from 14 to 17. A total of 5,473 children were taken into protective custody and an estimated 14,800 cases required follow-up. The largest number of neglect cases were categorized "lack of supervision," and of those, more than 6,000 were cases in which a caretaker was present in the home.

In response to the increase in reported child abuse and neglect cases and heightened public awareness of the size of the problem, a wide variety of prevention and treatment programs has been instituted. Many of these programs involve joint efforts and joint funding by state agencies and local governments or private groups.

*These statistics apply only to reports under the Abused and neglected Child Reporting Act.

Because teenage parents may be ignorant of child development, have few parenting skills and/or may suffer the stresses of unemployment, malnutrition and poverty, they are regarded as being at risk of child abuse. The need for adolescent parent education and support is recognized by programs such as the Ounce of Prevention Fund, a DCFS project in partnership with the Pittway Corporation. The main goal of the program is to prevent child abuse by providing services before abuse occurs. Services include drop-in centers, parenting education, access to pre and postnatal care, child care and development, counseling, drug abuse prevention and day care. The Parents Too Soon program, which aims primarily at preventing teen pregnancies and also serves teenagers who already have babies, provides many of the same services, sometimes in conjunction with Ounce of Prevention centers.

SAMPLE PROGRAMS

Various programs address aspects of the abuse and neglect problem. Some examples are:

- Family Advocates, Inc. in Rockford provides services to families identified by doctors and the courts as showing severe abuse within the family, to children who are victims of sexual abuse from outside the family, and to adults who were abused as children and are now seeking understanding and assistance.
- Child Sexual Abuse Treatment and Training Center of Illinois, Inc. in Bolingbrook treats sexual abuse victims of all ages; treats juvenile offenders and molesters and provides training for hospital staff, state's attorneys and doctors.
- The Child Abuse Unit for Studies, Education and Services (CAUSES), located at the Illinois Masonic Hospital in Chicago and funded through DCFS, works with certain mothers who have been committed to the Dwight Correctional Center.
- The Rape Information Counseling Service in Springfield and the Child Abuse Prevention Speaker's Bureau in Chicago teach young children how to deal with people who may make inappropriate advances and try to instill safety habits to prevent the children from being victimized.
- The Juvenile Protective Association, Chicago, is the lead agency in an effort by five voluntary agencies to provide services to children who are victims of such offenses as pornography and seduction and who have been referred by the Cook County State's Attorney's office.

A recent state law makes it possible for Illinois taxpayers to contribute up to $10 of their state tax refunds to the Child Abuse Prevention Fund. The fund is administered by DCFS to promote development of community services for abused children and various programs for the prevention of abuse. Grants totaling $414,000 were awarded to 32 non-profit agencies in 25 Illinois communities in January 1985.

MISSING CHILDREN

Although no reliable numbers on missing or runaway children are available, there are estimates of 1.4 million runaways nationwide. In Illinois almost 1,400 children are reported missing. It is possible that part of the apparent rise in the number of missing children is due to a divorced parent's abduction of or refusal to return a child to the custodial parent. Several tragic cases have brought this issue to national attention. In response, Congress passed the Missing Children's Assistance Act in 1982 to coordinate programs relating to missing children under 18 who may have been removed without the custodian's consent or under circumstances that strongly indicate that the child is likely to be abused or sexually exploited.

REFERRAL SOURCES

A national hotline is reserved for persons who have information which may lead to the location and recovery of a missing child. The national Runaway Switchboard offers counseling, referral services and confidential message relays. The Transitional Living Program has outreach workers in the Lakeview and Uptown areas in a program to offer services to exploited young people who may be engaged in prostitution or pornography.

Under the Illinois State Enforcement Agencies to Recover Children (I-SEARCH), the Department of Law Enforcement is authorized to provide partial funding for local efforts to locate lost, missing or runaway children and to establish an information network. Public education efforts include teaching children how to protect themselves against strangers, emphasizing the importance of family record keeping such as photos, physical and dental records and increasing awareness that there is no 24-hour waiting period before investigation of a missing child can begin. I-SEARCH also publishes a missing children's bulletin, available to interested persons.

A new child protection program, Kids in Illinois Deserve Safety (KIDS) is designed to promote child safety through public information campaigns and more severe penalties for offenses against children. KIDS calls for expansion of I-SEARCH, special training of state police officers to serve as child safety officers and a statewide clearing house of educational material on child protection issues.

The Illinois Criminal Justice Information Authority has been designated to administer funds from the Victims of Crime Act passed by Congress in 1984. Programs will focus on increased public education about victim rights and services, reimbursement services for victims, victim advocates in selected areas of the state and the development of model comprehensive programs. At present there is no indication how much of the funding will be allocated to services for children.

Referral Services for Abuse and Neglect

Department of Children and Family Services Central Registry
800-252-2873

Parents Anonymous
800-421-0353

Referral Sources for Missing and Exploited Children

I-SEARCH Hotline
800-U-HELP-ME

National Center for Missing and Exploited Children
1835 K St., N.W.
Washington, D.C. 20006
Hotline: 800-343-5678

National Runaway Switchboard
800-621-4000

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*FY 1984 refers to the fiscal year which ends in 1984.

Who Cares for Kids?
CHILD SUPPORT

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

DISSOLUTION OF MARRIAGE/DIVORCE

In Illinois both parents have a legal obligation to support their children until age 18. In the event of a divorce the court may order either or both parents to pay support. A law passed in September, 1984 established mandatory guidelines for the courts to follow in awarding child support. The guidelines are based on a percentage of the net income of the paying spouse (20 percent for one child, more for each additional child) and are binding unless the court makes "express findings of fact" which justify setting the award below the minimum required. Health insurance coverage for dependents must also be provided. These mandatory guidelines apply both to the dissolution of marriage (divorce) cases and the child support enforcement cases of the Department of Public Aid. Passage of the law was opposed by many who believed that mandatory guidelines bear little relationship to needs and the ability to pay and that financial responsibilities would not necessarily be divided equitably between parents.

Child support usually lasts until a child reaches the age of majority, which in Illinois is 18 years-of-age plus completion of high school. A provision for higher education is not automatically considered at the time of divorce. Anticipating such a need is the responsibility of the parents and providing for such expenses at the time of the divorce may help parents avoid the legal expense of returning to court to ask for modification of a settlement to provide a college education for the child. A support order remains in effect if the custodial parent remarries. Also, unless agreed upon by the parents, child support is not terminated by the death of a parent obliged to support the child. The estate of the deceased parent may be ordered to provide support.

The Illinois Marriage and Dissolution of Marriage Act allows modification of a child support award "only upon showing of a substantial change in circumstances," and the responsibility for proving that such a change has occurred rests with the parent seeking the adjustment. Possible reasons for modifying the support amount might be an increase in the child's needs, a large increase in the non-custodial parent's ability to pay or inflation. A supporting parent's responsbilities to a second family may be a factor in evaluating a request to modify the support to the first family, but cannot justify a failure to provide adequately for the first family.

The law does not guarantee that child support will be ordered in every case. In many instances, child support is not ordered because the income of the non-custodial parent is too low or non-existent, or because the absent parent's whereabouts are not known or paternity has not been established.

When child support is awarded, the average amount is low, deliberately set at a level which will give the supporting parent an incentive to keep working. It would be counter productive to set child support payments at such a high level that the supporting parent might prefer to stop working rather than pay the amount ordered. However, the amount of support awarded is often inadequate. (The national average is under $200 per month per family.) Since the custodial parent is most often the mother, who may have a considerably lower earning power than the father, an inequitable share of the burden may fall on the parent least able to pay. Low levels of support, coupled with the difficulties of caring for children and holding a job, all mean that the effects of divorce can be economically disadvantageous to custodial parents, usually mothers, even if the child support payments are received regularly and in full.

Unfortunately, non-payment of child support is a widespread problem of enormous proportions. Nationally, of the 8.4 million women raising children whose fathers were absent in 1981, about five million had been awarded child support. Slightly less than half of those received full payment, and one-fourth received none of the ordered support at all. This non-payment of support, which cuts across all income groups and bears little relationship to the absent parent's ability to pay, pushes many women and children into poverty. Unpaid child support is a major reason for needing public aid.

AID TO FAMILIES WITH DEPENDENT CHILDREN

The Aid to Families with Dependent Children (AFDC) program, administered by the Department of Public Aid (DPA), is designed to preserve and to strengthen family life primarily by providing financial and medical aid. AFDC adults and children up to 18 years of age are covered by Medicaid and are eligible for food stamps. In 1985 AFDC grant levels in the 14 Illinois counties with the highest cost of living were:

1985 MONTHLY AFDC GRANTS

Family Size	Cash Grant	Food Stamps	Energy Assis.	Total	DPA Standard of Need (SON)	Total Assis. as % of SON	Fed. Nonfarm Poverty Level
2	$250	$141	$8	$409	$480	85%	$560
3	341	177	18	536	$657	82%	705
4	385	219	18	622	$742	84%	850

Elsewhere grant levels were slightly less. To receive AFDC benefits an applicant must sign over the right to child support to the Department of Public Aid.

The AFDC program was first established in the 1930s to provide for children who needed support because of the death, absence or disability of a parent. Death of the father was initially the major basis for eligiblity, but the rising divorce rate and the increasing numbers of children born out of wedlock have made absence of a parent from home the major cause of AFDC dependency. The number of female-headed families has increased enormously in the last twenty years and now constitutes 19 percent of all families and 22 percent of families with children. The number of poor people in female-headed families has increased by 54 percent while the number in male-headed families declined by 50 percent. The vast majority of AFDC recipients are unemployed mothers with one or two children under seven years of age, although a small number are two-parent families without work. Four-fifths of welfare recipients live in female, single-parent families.

CHILD SUPPORT ENFORCEMENT

Concern about the cost of a rapidly increasing AFDC caseload and the low priority which was given to child support enforcement efforts by state and local governments led to the adoption in 1975 of federal legislation establishing the Child Support Enforcement Program. This provides federal guidelines and funding for state-operated programs to locate

parents who have deserted their families, to establish the paternity of children when they are born out-of-wedlock, to establish a legal obligation on the part of the absent parent to support that child, and to enforce that obligation. The emphasis is on securing support for AFDC recipients, although families not receiving public assistance may use the services. The federal government reimburses each state for a portion of the cost of the program. In addition, the money collected on behalf of AFDC recipients goes to federal, state and local governments as reimbursement for the costs of providing welfare benefits.

The Illinois Bureau of Child Support, located in the Department of Public Aid, is the agency designated to administer Illinois's Child Support Enforcement (CSE) program. For all AFDC cases, and for non-AFDC cases when requests are made, the Bureau must try to locate absent parents, establish paternity for children born out-of-wedlock, and obtain and enforce child support obligations. Illinois must also maintain a Parent Locator Service and cooperate with other states in locating absent parents and securing payments, as provided in the Uniform Reciprocal Enforcement of Support Act (URESA).

By the early 1980s serious attention was focused on the poor success rate of the CSE program in Illinois. The record for recovery of AFDC costs in Illinois was the lowest in the country. In FY 1981 only $13.9 million was collected, compared to $305 million in the highest state, Michigan. In an attempt to improve the situation, changes in administrative procedures and interception of income tax returns of parents owing child support for AFDC recipients began in 1982 resulting in increased collections. But the most important factor in increasing the efficiency of collecting child support payments was the institution of a system under which payments are made through the clerk of the circuit court in Cook County. Originally proposed as a mandatory system for all support cases in Illinois, the high cost of administering such a program led to requiring its use only in Cook County, which accounts for approximately half of the state's CSE expenditures and collections. Under this system the clerk forwards the support payments directly to the custodial parent, or to the DPA if the case involves a welfare recipient. In the event of a deliquency, the clerk's office automatically initiates collection proceedings. After two weeks the state's attorney's office is notified, and within 60 days enforcement proceedings begin, if necessary.

Despite this enforcement program, however, the law still required repeated trips to court for enforcement of unpaid child support. Enforcement through the clerk of the court could still take months due to administrative delays, the legal notification period and the wait for a court date. Therefore, the Illinois legislature passed an income withholding bill effective January 1, 1984 which requires that in every case where a child support order is entered, a separate "Order for Withholding" is also to be placed in the court file. This order will be activated if and when a deliquency in the amount of one month's payment of child support occurs.

When a one-month deliquency occurs, the "obligee" (the custodial parent of appropriate governmental office such as the DPA) must give the delinquent parent (or "obligator") notice of the delinquency and a chance to pay. If after 20 days support is still delinquent and no petition for a hearing on the matter has been filed by the obligor, the obligee can obtain a certified copy of the Order for Withholding from the Clerk of the Court to send to the obligor's employer or payor of income. The payor must take the amount specified in the Order out of the obligor's paycheck and send it to the proper party.

Wage withholding legislation has also been passed by Congress in the Child Support Enforcement Amendments of 1984 which require states to enact laws establishing procedures for (1) mandatory wage withholding from the paychecks of parents who are more than 30 days delinquent in making child support payements, (2) establishing liens against property for amounts of past due support, (3) deducting delinquent payments from federal and state income tax refunds for both AFDC and non-AFDC cases, (4) providing information to credit agencies on arrearages in excess of $1,000 and (5) expediting the process for establishing paternity.

REFERRAL SOURCE

Custodial parents in Illinois may use the income withholding procedures themselves, without having to hire an attorney. The illinois Task Force on Child Support, a consortium of agencies working to improve payment of child support, has prepared a handbook for custodial parents on how to obtain income withholding orders. The handbook provides a step-by-step description of how to use the income withholding order against a deliquent parent or ex-spouse without the need to use an attorney. Copies are available from the Task Force. The Task Force also operates a telephone information hotline that provides information and assistance to custodial parents and has developed a statewide network of organizations to ensure effective child support enforcement throughout the state.

Illinois Task Force on Child Support
343 South Dearborn, Room 804
Chicago, IL 60604
Phone 312-341-0013

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67 E. Madison Street, Chicago, Illinois 60603

Who Cares for Kids?
DAY CARE AND EARLY CHILDHOOD EDUCATION

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

NEED FOR DAY CARE SERVICES

Demands for day care services have increased rapidly over the last decade as a result of social, economic and political changes. The main reason for this has been the increase in the number of employed mothers. According to the Children's Defense Fund (CDF) in March, 1984, over 50 percent of mothers with children age three to five are working. Even when the youngest child is under three, about 65 percent of employed mothers are full-time workers. The availability of child care has thus become a major requirement of the labor market in the 1980's, yet the supply lags far behind the need for services.

Two-thirds of employed women are either sole providers for their children or have husbands who earn less thatn $15,000 per year according to a 1983 CDF study. Three-fifths of employed women earn less than $10,000 a year, and one-third earn less than $7,000. Eighty percent are concentrated in the 25 lowest paying job categories. More than one-third of single parent families, most of them headed by women, live in poverty. Lack of affordable child care is a major factor in the ability of low income women to work and to support their families.

SUBSIDIZED DAY CARE

Funding for publicly subsidized day care is derived from federal, state and local sources. Federal funds are provided through Title XX of the Social Security Act (Social Services Block Grant). In 1981 the grant was cut over 21 percent and the child care food program which provides meals to children in subsidized care was cut 30 percent. Since that time almost every state has reduced the funding of child care for low-income families. Illinois was no exception. The number of subsidized day care slots has declined from 28,000 (25 percent of total licensed capacity) in 1981 to 17,000 in 1984.

Illinois Title XX regulations state that fees for day care shall be paid on a sliding scale based on family income and number of children, providing a range from full subsidy to none. The bulk of day care funding is channeled through the Department of Children & Family Services (DCFS). The Department is responsible for coordinating and planning day care services in Illinois. In 1973 the Department created the Division of Child Development which plans, licenses, gives technical assistance to, evaluates and monitors day care centers and homes. The Department of Public Aid and the Illinois State Board of Education have small programs for public assistance recipients. Of the funds administered by DCFS, the non-federal share of subsidized day care is provided through state general revenue (appropriated funds) by local governments in what is termed the Certified Local Effort and by other local donors in the Local Initiative Effort. In recent years the largest amount of non-federal money has come from local government funds. Revenue sharing funds have been a source of support for day care in many localities.

At present there are 17,000 available subsidized day care slots in Illinois, but there are an estimated 40,000 eligible children, of whom about 10,000 are on active waiting lists. For example, the Family Service Center of Sangamon County, an agency providing foster care, adoption, counseling, parenting education and other social services in addition to subsidized day care, has a capacity of 141 children with 20 slots for infants. The waiting list is 800 — 480 for infant care and 320 for preschoolers.

The uneven distribution of available day care is a problem as well as the lack of sufficient subsidized day care slots. In some communities there may be no services at all. In others parents may have no way to transport children long distances to day care centers or homes. In the Chicago metropolitan area where there is a variety of possible day care arrangements and a public transportation network, the situation is somewhat better. However, parents everywhere must often depend on relatives, neighbors, baby sitters and parent cooperatives to obtain care for their children.

PRIVATELY FUNDED DAY CARE

Those who can afford to pay for day care are eligible for some federal income tax credit, depending on their income. Costs for day care, however, are high, particularly for infant care. The cost of unsubsidized day care for infants in a licensed center in the Chicago area runs from $60 to $100 per week and in a licensed home from $50 to $150. Costs of unsubsidized care for preschoolers in a licensed center or home is in the range of $35 to $75 per week. Downstate rates are somewhat lower. As far as subsidized care is concerned, one not-for-profit day care facility which cares for infants in Chicago estimates the cost at about $20 per day, but the state reimbursement at present is only $11.93 per day (although it is soon to be raised to approximately $16). It is thus extremely difficult for a mother working at a low paying job to make up the difference, and at the same time it is impossible for this center to expand its infant capacity, even though the center has a waiting list of 300. Yet is is estimated that 46 percent of mothers with infants under one year of age are in the work force. Infant care is also a critical need for teenage mothers who are attempting to complete high school.

DCFS requires that a licensed day care center or home provides a child with a safe, stimulating environment for the hours away from home. The staff/child ratio for three, four and five year olds should 1:7, and for infants and toddlers 1:4. Teachers and aides providing direct care must have training and education for their jobs. Parent participation is demanded. Space requirements of the State are enforced. Workers are adequately reimbursed to enhance staff stability.

LICENSING

Illinois licensing requirements set standards for the physical environment and staff of day care homes and centers. Child care workers in centers must have completed two years of college with six semesters in child development, child care or psychology or have a combination of one year supervised experience with children in a nursery school, kindergarten or licensed day care center and six semester hours in child development and child care. Home care providers must exhibit competence in knowledge of child development, hygiene, safety, nutrition and in communicating with children and their parents. Under a new state program, Illinois day care centers will be required to distribute information to parents explaining how to evaluate a day care facility and to identify symptoms of abuse and disease.

Although prior to 1982 all day care homes were required to be licensed, at present church-sponsored day care centers and day care homes serving three or fewer children need not meet licensing standards. This leaves an unknown amount of day care unregulated and unlicensed. At present DCFS licenses

2,325 centers and 5,277 homes serving a total of 40,500 children.

EARLY CHILDHOOD EDUCATION

Nationally the number of three and four year old children in formal preschool programs nearly doubled between 1970 and 1982. Enrollment of five year olds in preschool programs grew from 69 to 83 percent in the same period. In Illinois in 1983-84 there were 11,717 children enrolled in public school pre-kindergarten programs and 8,617 in special education pre-kindergarten. Enrollment patterns were closely related to socioeconomic status with participation rising with higher income. This situation in turn has led to subtle shifts in public attitudes with day care and early childhood education no longer as closely identified with the poor as they once were.

Growing evidence confirms the significant long-term benefits of early childhood education and has shown that preparation for schooling greatly increases a child's chances of success. The acknowledged impact of the Head Start program is well-known. Another recent confirmation is the reasearch done by the Perry Pre-School Project in Ypsilanti, Michigan. In the early 1960's the project offered one to two years of education to three-year-olds from impoverished backgrounds who had below average IQs of 60 to 90. Results have shown that children in the program graduated from high school and went on to jobs or further education at nearly twice the rate of children in a control group who did not take part. There were also fewer arrests, detentions and teenage pregnancies among graduates of the program. Positive results were also reported in Colorado where a study of four school districts found that costs of preschool programs were recouped within one year through a reduced need for special education.

A program offering one or two years of preschool is presently operating at 25 sites in poor neighborhoods on Chicago's west side. A statewide Transition and Independence (TRAIN) program has been proposed to set up similar preschool education learning centers to help three or four year old children develop learning readiness skills.

A model early development (infant stimulation) program for handicapped children, *Lekotek*, a Swedish word for "play library", enables trained staff to work with parents and children in therapeutic play with toys provided on a loan basis so parents can continue to work with their child at home. The first program opened in Evanston in 1980. Newer programs include the Clearbrook Center in Rolling Meadows, an outreach program at the Augustana Center for Developmentally Disabled Children in Chicago and a follow-up to the program at the Institute for the Study of Developmental Disabilities located on the campus of the University of Illinois at Chicago.

AFTER SCHOOL CARE

After school care is another unmet need. Children who have no supervised care after school have become latchkey children. Many children as young as ten years of age are responsible for the care of younger siblings. There is no reliable estimate of how great the need is, but agencies and centers generally have not found providing services for this group profitable. It is not profitable for the for-profit center and difficult for the not-for-profit facility which must allocate a space for a child who only uses it for a few hours. Subsidies, if the child is eligible, are only a fraction of the daily rate.

In some states, one solution for this particular problem is the use of public schools as care centers. This public/private cooperative arrangement is cost effective and an excellent use of existing resources. A variety of arrangements are possible. A school district may operate its own program directly or may contract with a private care provider who may lease space from the district. Types of care usually include before and after school but may also offer extended kindergarten and preschool care.

One example of a comprehensive day care program operates in the school district in Lincolnwood. A private not-for-profit care provider leases space from the school district. Before and after school care is provided for pupils. Care is also available for infants, toddlers, two and three year olds and preschoolers. Teachers are certified and required to have degrees in early childhood education. Weekly rates are $97 for infants, $88 for toddlers, $82 for older two and three year olds, and $72 for preschoolers. The staff/child ratio is 1:4 for infants and correspondingly low for older groups. Emphasis is placed on providing a stimulating enrichment and socialization program.

EMPLOYER CONTRIBUTIONS TO DAY CARE

Nationwide only two percent of large corporations provide on-site care for employees' children. Although some hospitals, companies and factories have initiated child care programs for their workers, this kind of care is not widespread because of its high costs. However, some industries have helped employees in other ways, including direct subsidies, subsidized slots in a nearby center for employees' children and development of information and referral services.

One example of a corporation which provides day care for employees' children is Fel-Pro Corporation in Skokie. At a cost of $50 per week to the parent, children age two to six are cared for in a separate building at the plant site. Fel-Pro calculates the actual cost at slightly more than $100 per week but shares the cost with the parents. The staff ratio is 5:1. The program, which also includes a regular kindergarten, emphasizes social and emotional growth and preparation for school.

RECOMMENDATIONS FOR THE FUTURE

During 1983-84 the House Select Committee on Children, Youth and Families studied the nation's child care issues in a series of hearings and site visits and recommended the following:

- Tax credits for employers who set up on-site day care facilities for children of their employees,
- Further tax credits for parents to help meet day care expenses,
- An increase in money for Title XX of the Social Services Block Grant,
- Federal aid to school districts to set up before and after school programs for latchkey children, and
- Incentives for the creation of child care research and referral centers so parents will know what options are available in their communities.

REFERRAL SOURCES

The Day Care Action Council of Illinois, a group committed to insuring the existence of day care for working families, sponsors the Day Care Connection in the Chicago area. The Connection is a referral source for parents and helps them choose a quality day care situation. Information and assistance may be obtained from the Council, local offices of the Department of Children & Family Services and, in some instances, from community referral services and social service agencies.

Day Care Action Council of Illinois
4753 N. Broadway, Suite 726
Chicago, IL 60640
312-561-7900

Day Care Connection
312-348-WORK

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67 E. Madison Street, Chicago, Illinois 60603

Who Cares for Kids?
DRUG AND ALCOHOL ABUSE

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

In Illinois, as throughout the United States, the precipitous increase in drug and alcohol abuse among young people is a major problem. A 1984 survey by the federal National Institute on Drug Abuse found that 29 percent of high school students reported some illegal use of drugs each month and 40 percent reported alcohol misuse. The use of hallucinogens and phencylidine (PCP) seems to be declining, but cocaine is increasingly popular and alcohol remains the top drug of choice. There is also increasing use of drug combinations and the use of alcohol with other drugs.

A recent report to the Illinois General Assembly estimated that 40,000 to 50,000 Illinois residents are abusers, including an estimated 25,000 youth. The Department of Alcoholism & Substance Abuse (DASA) reports that half the population under the age of 18 are at risk of becoming abusers and that drug and alcohol abuse are the leading causes of death in the 16 to 24 age group. A recent study has revealed from 80 to 90 percent of high school students in the northwest suburbs of Chicago are users of chemical substances. Directors of alcohol/substance abuse treatment programs are finding that most of the youth who are taking drugs are multi-drug users and that there is an increasing number of younger children from junior high who are using alcohol and chemical substances.

STATE SERVICES FOR DRUG & ALCOHOL ABUSE

State services to combat the problems of substance abuse are consolidated in the Department of Alcoholism & Substance Abuse (DASA) which combines the functions of the previous Division of Alcoholism of the Department of Mental Health & Developmental Disabilities (DMH/DD) and the Dangerous Drugs Commission. The mandate creating DASA contains the following statement. "It is the public policy for this State that the human suffering and social and economic loss caused by the illness of alcoholism, addiction to controlled substances, the use of cannabis, and the abuse and misuse of alcohol and other drugs are matters of grave concern to the people of the State. It is imperative that a comprehensive and coordinated strategy be developed thorugh the leadership of a consolidated and functionally integrated State agency..." Key elements of the strategy include a broad spectrum of prevention programs, especially for youth and other groups at risk of developing substance abuse problems. The agency is required to develop an annual plan and to seek input from providers, parent groups, agencies and interested citizens.

DASA administers funds from the federal Alcohol, Drug Abuse and Mental Health Block Grant, the Social Services Block Grant and general revenue funds from the state of Illinois. In addition, the new Juvenile Drug Abuse Fund permits support of youth services through the collection of 12½ percent of fines levied in Illinois local jurisdictions against persons convicted of violations of the Controlled Substances Act.

DASA funds and monitors alcoholism treatment programs, although the Department of Public Health is the regulatory agency. DASA funds, monitors and licenses drug programs. Among the projects funded by DASA in FY 1985* were 35 community-based prevention programs. DASA will also provide funding for the Prevention Resource and the Illinois Alcoholism and Drug Dependence Association (IADDA) prevention initiatives. DASA plans a wide variety of interagency cooperative efforts such as participation and support of the Parents Too Soon Project, the Illinois Teenage Institute, the Tri-Agency Project and the Children's Policy Group through the Office of the Governor with special attention to the service needs of children with multiple problems.

The Division of Prevention and Education within DASA provides planning, coordination and leadership in the prevention area. Through the Illinois State Board of Education (ISBE), DASA can initiate alcohol and drug abuse prevention programs in school districts throughout the state. Programs may be developed to provide parents, school officials, local drug and alcohol prevention service providers and other interested groups with the opportunity to plan and to develop prevention programs that are tailored to meet the specific needs of the children and adolescents in each school district.

A significant emphasis on family services is a part of all licensed drug and alcohol treatment and prevention programs in Illinois. Sustained treatment programs in both alcoholism and substance abuse include family therapy as a regular part of clinical services in recognition that the drug abuser and/or the alcoholic does not exist in a vacuum. Early intervention and prevention programs include information for families, parents and significant others such as educators and juvenile court personnel who may be involved in the life of the adolescent at risk of alcoholism or substance abuse.

An early education prevention program, Starting Early, has been made available by the American Automobile Association through ISBE. The curriculum, designed for youngsters in kindergarten through sixth grade, is intended to prepare children for alcohol-related situations by teaching about the influence of alcohol on mind and body and the potentially dangerous consequences of alcohol misuse. A multi-problem prevention program is the Drug/Alcohol/Truancy Prevention and Education Project of the Grundy/Kendall counties Educational Service Region. The program includes classroom presentations for fourth, fifth and sixth graders, presentations to community organizations and the general public, and in-service training for teachers in the areas of drug/alcohol/truancy prevention.

Within its treatment responsibilities DASA's Youth Initiative Program involves the development of comprehensive demonstration program models for the treatment of alcohol and substance abusing youth. The Youth Initiative identifies effective treatment methods and develops programs designed to increase early intervention with substance abusing youth and develops programs to demonstrate effective networking of available resources, thus increasing the referral, early intervention and treatment possibilities. The three demonstration projects represent urban (Chicago), urban/rural (Bloomington) and rural (Marion) settings. Each offers a combination of residential, outpatient and rehabilitation services for substance abusing youth.

DASA presently contracts with 17 facilities in various parts of the state to provide inpatient residential care specifically for youth and with 19 facilities to provide inpatient treatment for

youth and adults combined. There are 99 treatment providers of outpatient programs for youth only or for youth and adults. Detoxification is provided specifically for youth at 24 facilities.*

Detoxification, the reducing and eliminating of the drug or alcohol from the body, may take place in a medical facility, residential treatment setting or a home. Outpatient programs, for those who do not need 24-hour care, may be as intensive as three hours per day, five days a week, although weekly appointments are more common. Outpatient treatment may also include support services such as family counseling and involvement with Alcoholics Anonymous. Inpatient residential care programs provide 24-hour care. Programs are of varying lengths, ranging from sixteen days to nine months, and may include detoxification, counseling, educational and transitional services. No drug abusing juvenile may be turned down by a DASA licensed treatment center for financial reasons, although a juvenile may be rejected because he/she is not ready to accept treatment help.

In most cases substance abuse treatment is voluntary; however, some persons may be ordered to undergo treatment. Minors may be required to participate in appropriate programs as part of court supervision, as a condition of probation or, if found to be an addict (as defined in the Alcoholism and Substance Abuse Act) or an alcoholic (as defined in the Alcoholism and Intoxication Treatment Act) may be placed under the treatment supervision of DASA as a disposition under the Juvenile Court Act.

SAMPLE DRUG AND ALCOHOL PROGRAMS

One example of a treatment program for substance abusers is the Treatment Alternatives to Street Crime (TASC), a private non-profit organization. Better known for its work with adult offenders, TASC presently has two programs serving juveniles, one in Peoria and another which started in Cook County early in 1985. TASC conducts screenings for the court, either as a diversion or as a condition of probation. In Cook County TASC will work with those assigned to Intensive Probation Supervision units and with repeat offenders when substance abuse is indicated in the social history.

The Prevention Resource Center, a project of Awareness House Training and Development Systems, offers technical assistance to any group, school or community wishing to set up a substance abuse prevention program. The Center's services are free; they also publish a newsletter, *Prevention Forum*. A wide variety of community-based prevention, education and support programs have been established in various parts of the state. Some schools and/or local groups sponsor Al-Anon, Al-Alteen or SADD (Students Against Drunk Drivers) groups, alternatives to suspension programs and student education and leadership opportunities.

One of the leading statewide organizations in the alcohol and drug abuse prevention and treatment field is the Illinois Alcohol and Drug Dependence Association (IADDA). Founded in 1967, this non-profit organization has more than 1,000 members including teens, adults, professionals and volunteers. Among its various activities IADDA organizes committees to discuss current issues in the alcohol/substance abuse field. The goals for its Youth Committee are to develop positions on pending legislation for financing prevention and treatment services; to ensure communication among volunteers and professionals; to advocate that more attention be given to youth in the field of alcohol/drug abuse; and to assist DASA in developing cooperative projects with other youth serving agencies. The IADDA newsletter, *Focus*, is helpful to keep aware of the services and programs available on alcohol and substance abuse. IADDA also publishes *Snow-Mentum*, the official newsletter of Operation Snowball.

Operation Snowball, with chapters throughout Illinois, is a program of youth helping youth, designed to promote personal growth and to encourage healthy and socially acceptable living habits. "Feeling good without drugs" is the essence of this program. A one-day program called Snowflake has been developed for grade school children. Operation Snowball is a winner of the National Council on Alcoholism's Meritorious Award for prevention and treatment.

The Illinois Drug Education Alliance is an organization of representatives from parent groups in Illinois communities. IDEA, a non-profit organization, publishes a newsletter and holds meeting and conferences to assist parent groups in exchanging ideas on substance abuse education and prevention programs.

The Substance Abuse Prevention and Treatment Directory, available free from the office of the Lieutenant Governor, lists treatment facilities, community groups and other resources throughout the state.

REFERRAL SERVICES

1-800-COCAINE

1-800-252-6301, Illinois Alcoholism and Drug Dependence Association (IADDA)

Office of the Lieutenant Governor
214 State Capitol Building
Springfield, IL 62706
1-800-252-6584

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*FY 1985 refers to the fiscal year which ends in 1985.

*See the Substance Abuse Prevention and Treatment Directory for locations.

Who Cares for Kids?
EDUCATION FOR SPECIAL NEEDS
Truancy, Vocational Education

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

The educational development of all persons to the limits of their capability is a fundamental goal under the Illinois Constitution. Education is the service that reaches nearly all children and represents the largest single expenditure for children in the state's budget. Eighty-five percent (1,800,000) of young people of elementary and secondary age in Illinois are enrolled in public schools. More than one of every ten pupils receives special education for the handicapped (ranging from a student with a slight speech defect to the severely and multiply-disabled), and one out of twelve receives some compensatory education due to cultural, economic or language disadvantages. Approximately 6 percent are in transitional bilingual programs and about 25 percent of public high school seniors are enrolled primarily in vocational education programs.

For some students the goal of full educational development falls short. Only 65 percent of those eligible are served by compensatory education programs and requirements for transitional bilingual programs are such that many individuals and language groups go unserved. For others the school environment may not be conducive to learning. One percent of the public school population is chronically truant, absent without valid cause for 10 out of 40 consecutive school days. In 1984 the dropout rate was reported at almost 50 percent for Chicago public schools and 20 percent for other parts of the state. According to the Chicago Board of Education, in some schools with high concentrations of Hispanic students the dropout rate was as high as 75 percent.

ILLINOIS STATE BOARD OF EDUCATION

The state agency responsible for setting educational policies and guidelines for schools through grade 12 is the Illinois State Board of Education (ISBE), which also has the responsibility for vocational education. The state is divided into Educational Service Regions, each headed by a regional superintendent whose duties include the supervision of local school boards and administrations, the distribution of state monies to the schools and the handling of truancy problems in the region. The operation and maintenance of local schools in the 998 elementary, secondary and unit districts is the responsibility of local boards of education. Funds for the schools come from the federal and state governments and from local property taxes.

SPECIAL EDUCATION

Illinois law requires that a free public education through grade 12 be available for all children. The broadest responsibility for children with special needs comes from the federal Education for All Handicapped Children Act of 1975 (PL 94-142) which requires that all handicapped children be provided a "free and appropriate public education." The Illinois School Code directs local school boards to "establish and maintain such special education facilities as may be needed for handicapped children...who are residents of their school district." Local school districts may develop services, join with another district or purchase day or residential services.

All handicapped children between the ages of three and twenty-one are to be identified, located and evaluated. An Individualized Education Program (IEP) is developed for each child and reviewed at least annually. Special education and related services are made available at public expense; the cost is shared by the state, federal government and the local school district. Of 241,389 children receiving special education services in 1983-84, 10,036 were trainable mentally handicapped, 24,387 educable mentally handicapped, 4,092 physically handicapped, 94,646 learning disabled, 1,212 visually impaired, 1,812 hard of hearing, 1,678 deaf, 78 deaf/blind, 72,125 speech impaired, 8,387 educationally handicapped, 20,945 behavior disordered (the special education designation for emotionally disturbed) and 1,991 with other handicaps.

The School Code specifies that whenever possible special education students should be served in their local public schools or mainstreamed, so that they will have an opportunity to be educated with children who are not handicapped. At present approximately 90 percent of special education pupils are served in a local public school setting.

Federal and state reimbursements are based on the number and kinds of services. In 1984 the state reimbursed local districts for the transportation for 69,309 students either because of the program's distance from the local school or the child's handicap, for 30,380 children requiring extraordinary special education services, for 16,716 children in summer school programs and for 5,016 children in foster family homes or residential facilities. Costs of tuition, room and board were paid by the state for another 7,121 children in private residential facilities after approval by the Governor's Purchased Care Review Board. Placement in a residential facility, which may be very expensive, is the plan of last resort and is considered only if the local district cannot serve the needs of the child.

In 1983 in Illinois there were 18,118 behavior disordered children served in the public schools, 2,019 in private day schools, 316 in private in-state residential facilities and 219 in private out-of-state residential facilities. In the past several years there has been a trend to place fewer children out-of-state, but figures also show that an increasing number of children and adolescents are being served under the behavior disordered category and are requiring residential placement.

Young people in state facilities must also receive an appropriate education. The Department of Corrections (DOC) is unique in having its own school district. Compensatory and special education programs are provided to eligible persons in both the Juvenile and the Adult Divisions. The Department of Mental Health & Developmental Disabilities (DMH/DD) provides special education to hospitalized mentally ill and developmentally disabled children and adolescents. The Department of Rehabilitation Services (DORS) operates three schools for students with severe handicaps who cannot be served in the community. An Individualized Written Rehabilitation Plan addresses realistic long-term goals for these students, many of whom have secondary handicaps. In 1984 the Illinois School for the Visually Impaired (Jacksonville), the Illinois School for the Deaf (Jacksonville) and the Illinois Children's School and Rehabilitation Center (Chicago) served a total of 540 students: 118 severely visually handicapped, 27 deaf/blind, 320 deaf and 75 orthopedically impaired children.

TRUANTS/DROPOUTS

Chronic truancy and dropping out of school may handicap young people, reducing their educational opportunities and eventually the ability to lead a self-sufficient adult life. The cost of an incomplete education may also heighten costs to society through unemployment, delinquency and dependence on welfare for support. Truancy, aside from its social costs, has a financial impact on the local school district since state aid is tied to attendance levels. Truancy is highly concentrated. Ninety-eight school districts in Illinois, representing over half the public school enrollment, account for 88 percent of the chronic truants.

At one time truancy was grounds for commitment to the Department of Corrections, but gradually it has come to be regarded primarily as a social or educational problem. Sanctions may be applied against the parent under the School Code, however. Although a youth may no longer be brought to juvenile court for being truant, youths who come to the attention of the courts for other reasons may be ordered by the judge to pursue a course of study or vocational training. When school attendance is ordered as a disposition, chronic truancy must be reported to the juvenile court.

Programs for Truants & Dropouts. Early diagnosis, coordinated state/regional/local prevention efforts, alternative education programs and access to services are recognized as important elements in reducing truancy and dropout rates. The success of early childhood education programs such as Head Start has shown that compensatory programs should not be delayed until high school. Growing evidence confirms that preparation for schooling greatly increases a child's chances of success. A statewide Transition and Independence (TRAIN) program has been proposed to set up preschool education learning centers to help three- and four-year-olds develop learning readiness skills. In another proposal, full-day kindergarten would be offered in every local district, partially funded by the state.

In 1984 the ISBE Truancy Prevention program served 2,200 students in 13 programs, primarily for diagnostic services, at a cost of $600,000. School districts have adopted various strategies to combat truancy. The Options to Prevent Truancy program in Decatur middle schools focuses on prevention. The part-time work program in Macoupin County provides a potential chronic truant an opportunity to be hired for one hour a day in-school service. The Madison County project focuses on early reinforcement of good elementary school attendance procedures. Project TAP (Teen Action Program), which has several sites in the southern part of the state, is targeted at junior high and high school students with low self-concepts who are beginning to be absent. The program includes community services and some peer counseling. Referrals come from the schools; and although the groups are directed by older youths, some teachers are involved.

Relatively few programs are available to address the problems of dropouts. Among them are: Chicago United, a coalition of business and civic leaders which works with Farragut High School and Dunbar Vocational to help potential dropouts in a program that promises each participant a summer job in return for volunteering for special help in reading, writing and mathematics; the Industrial Skills Center in Chicago which serves dropouts who want to return to school to learn a skill; and Lake View High School's Teen Outreach Program which attempts to keep potential dropouts in school through a combination of regular classes and volunteer work for which the student can earn credit.

State funding for diagnostic/preventive/alternative programs in districts with the most severe problems of chronic truancy and pilot projects targeted on dropout-prone youth has been proposed. The Department of Law Enforcement would provide technical assistance to districts that have unsafe schools due to crime, violence, vandalism, drug trafficking and truancy.

EDUCATION FOR EMPLOYMENT

In 1983 there were 463,339 secondary students in vocational education, 332,987 in post-secondary/adult programs, and 28,615 adults in secondary programs, provided through ISBE's Department of Adult, Vocational and Technical Education. Almost one-fourth of the students enrolled in these programs were minorities, five percent were handicapped, 21 percent were disadvantaged and one percent had limited English language proficiency. An additional 8,865 students were in cooperative educational programs for potential school dropouts, handicapped persons and young adults lacking salable job skills who had previously dropped out of school. Programs offered included General Education Degree Development (GED), English as a second language, citizenship and programs for public aid recipients to enable them to achieve independence.

Federal funding for Work Experience and Career Education Programs (WECEP) is available to students in only 42 of 145 eligible school districts. The program serves 14 to 16 year olds who are academically or economically disadvantaged by providing special tutoring and by emphasizing parental involvement. The on-the-job experience is a valuable learning opportunity, and in some cases the earnings make the difference between staying-in or leaving school. Disabled students attending public schools may participate in Secondary Work Experience (SWEP), which provides counseling, guidance, diagnostic evaluation and assessment for placement through contractual arrangements between the district and the Department of Rehabilitation Services.

The Career Development Center Program, a joint effort of the Chicago public schools and Chicago United, is an example of a career education program. Students divide their day between attending school and working in one of fifteen career areas.

The Job Training and Partnership Act of 1982 (JTPA) was set up by federal legislation to establish job training programs for disadvantaged persons who face serious barriers to employment, including ex-offenders, school dropouts, teenage parents and the handicapped. Forty percent of JTPA funds must be targeted on youth. JTPA funds are distributed through local Private Industry Councils (PICs) to sub-grantees who provide basic job training. The Act is funded at approximately half the level of the program it replaced — the Comprehensive Employment and Training Act (CETA) — and does not continue the public service employment that enabled many persons, especially minority teenagers, to find jobs. After the first year of operation in Illinois, JTPA reportedly serves only 4 percent of the eligible population.

FUNDING

Federal funding for education and training includes the Education for All Handicapped Children Act of 1975, Chapter 1 of the Education Consolidation and Improvement Act of 1981. This Act provides compensatory education for certain students under age 20 who have not completed grade 12, and the Vocational Education Program, administered by the Illinois State Board of Education. The designated state agency for the Job Training and Partnership Act of 1982 is the Department of Commerce & Community Affairs.

REFERRAL SOURCE

Coordinating Council for Handicapped Children
220 South State
Chicago 60604
312-939-3513

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67 E. Madison Street, Chicago, Illinois 60603

Who Cares for Kids?
HEALTH CARE
Physical and Developmental Disabilities

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

In a November 1984 report the Committee on Access to Health Services of the Illinois Commission on Children designated the following services as essential for children and youth: prenatal care; family planning; screening for genetic disorders; genetic services; nutrition for pregnant women, infants and children; health supervision of infants and children; immunizations; vision and hearing screening and testing; school health and dental services.

The Department of Public Health (DPH) is the state agency responsible for programs and regulations that foster better health care in Illinois. The Department is the licensing agency for medical facilities, administers various federal funds, maintains all vital records and provides basic health grants to local health departments.

ESSENTIAL SERVICES

Prenatal Care Illinois has the country's fifth highest infant mortality rate, defined as the rate of death during the first year of life. A goal of the DPH is to reduce the infant mortality rate by 1990 to no more than 9 per 1,000 live births. In 1984 this rate averaged 11.9, the rate for non-whites was double that number and ran as high as 55 per 1,000 in the Avalon Park section of Chicago. Nationally three-quarters of all neonatal deaths are related to low birth weight (under 5½ pounds), which in turn are related to poor nutrition and prenatal care. Late or no prenatal care is reportedly increasing for non-whites. Fifty-five percent of teenage mothers receive no prenatal care in the first trimester. Surviving low birth weight babies are more likely to suffer handicapping conditions which may require long-term, expensive treatment, often at public expense.

Family Planning Services Illinois family planning services are available through private physicians, family planning clinics and community health centers. Nationally an estimated 2.8 million unplanned pregnancies occur each year. Recent reports from the Alan Guttmacher Institute indicate that teenage pregnancy rates are far higher in the U.S. than in five other countries surveyed, especially in the 15-to-17 age group. A correlation between effective family planning, sex education, contraceptive use and lower rates for teen pregnancy has been suggested.

Screening for Genetic Disorders All newborns in Illinois are tested for metabolic disorders so that prompt treatment can reduce or eliminate disabling conditions. Sixty-three cases were confirmed in 1984. The DPH plans to develop a system for tracing children with metabolic disorders.

Genetic Services The Department of Public Health, through a federal grant, will provide genetic counseling and educational programs concerning genetic disease. Funding will allow a genetic associate to be stationed in five areas of the state, with appropriate laboratory support.

Nutrition for Pregnant Women, Infants and Children The Special Supplemental Food Program for Women, Infants and Children (WIC) is limited to low- and moderate-income families with children. Nationally this program is estimated to reach one-third of those now eligible. Other responses to nutritional needs include the food stamp program and the school milk, needy breakfast and lunch programs. Nevertheless, in 1983 more than one-third of the children brought to the pediatric emergency room of the Cook County Hospital exhibited growth problems related to poor nutrition. The DPH has identified three high risk groups of low-income children under five. There is a high prevalence of stunting among Asian children; obesity is associated with Hispanics and anemia with blacks.

Health Supervision of Infants and Young Children Many parents have no regular continuing source of care or opportunity to receive medical advice and education about their child's health. This means that many children do not receive regular checkups during their early years. Prevention and early treatment of illnesses are therefore limited.

Immunizations In 1979 less than 50 percent of Illinois school children had received all required immunizations and less than 40 percent could provide proof of physical examinations. Although contagious diseases are no longer the killers they once were, occasional outbreaks can have long-lasting consequences. Almost 70 percent of the deaf/blind students enrolled in 1981 at the Illinois School for the Visually Impaired (Jacksonville) were born during the maternal rubella outbreak of 1964-66. With changes in law and with federal support, compliance with immunization requirements for five-to-fourteen year olds has risen to 90 percent. Children without proof of immunizations may be excluded from school and compliance is enforceable through withholding of state school aid. The Department of Public Health supports this policy; however, there is a move by education to eliminate certain examinations, reporting and financial penalties.

Vision and Hearing Screening and Testing Despite the proven effectiveness of early detection and remedial treatment prior to entering school, less than 50 percent of the state's three-to-five year olds have been screened for vision and hearing disorders. These handicaps are often linked to later behavior problems. Older children may be screened through the schools. The DPH will place a higher priority on resources for followup and treatment services.

School Health Eighty-four percent of the public school population is in districts served by a school nurse. With a ratio of close to one nurse for every 2,150 students, this may have little effect on the health care of individual students. In the future the School Health Program may be called upon not only to respond to the needs of handicapped children who are mainstreamed in public schools but also to provide primary health care to students in medically underserved areas.

Dental Services An estimated 500,000 children under 12 years of age have never received dental care, although these services are reimburseable by Medicaid. An example of the Department's emphasis on education and prevention is a program of regular dental care for 18,000 Head Start children age three-to-five.

Spinal Screening The Department recognizes the need for periodic screening for early detection of curvature of the spine. Over 20 states require such screening as part of their child health programs.

ACCESS

Two million people live in areas of Illinois where there are shortages of primary care physicians and dentists. Almost two-thirds of the state's population live in areas covered by a local health department certified by the DPH for basic health programs of agency administration, child health care, chronic disease control, communicable disease control, food, sanita-

tion, maternal health and family planning, nuisance control, potable water supplies, solid waste and private sewage disposal. Although the Department is helping to develop additional local departments, 13 percent of the state's population live in areas not served by any local health department.

Local health departments receive public funds through the Department of Public Health as well as from such third party payers as Medicaid and private insurance plans. Some funds come from patient's fees, often on a sliding scale. Most local health departments provide prenatal care, immunizations, vision and hearing screening and testing, well baby clinics and client referrals to other agencis for family planning or dental services if they do not provide those services.

Community Health Services There are 14 federally designed community health centers in Illinois: five in Chicago, one each in Rockford, Champaign and Decatur, and the others in more rural areas — Murphysboro, Christopher, Henderson County, Hopkins Park, Cairo and Anna. The Mile Square Health Center, Inc., one of the oldest in the country, is allied with the Rush-Presbyterian-St. Luke's Medical Center. It receives 15 to 20 percent of its funding directly from the federal government. The Center offers a full range of services including preventive and mental health care within its medical structure. With the exception of the mental health and Parents Too Soon programs which have some outreach staff, funding is no longer available for non-medical community workers to reach out into the community to bring back patients who do not follow their medical plan. However, the Center has opened several satellite clinics and, with the aid of federal grants, expects to expand services in the neighborhoods.

A school-based health clinic, modeled in part on one in St. Paul, Minnesota, is planned for the Du Sable High School in Chicago. The clinic will provide all primary care for students just as if they were seeing their own family physicians. Funding is unique in that it combines a consortium of private foundations with state funding. Other similar programs throughout the country are either public or private.

PHYSICALLY DISABLED

Financially and medically eligible children may be evaluated through a statewide network system and offered specialized medical care in the community through the University of Illinois Division of Services to Crippled Children (DSCC). Medical conditions for eligiblity include orthopedic, neurologic and cardiac defects or disease. In 1983 over 7,000 cases were added, for a total caseload of 30,000. The largest number of children received services for hearing loss, while the most expensive care was given to cardiac patients.

DSCC is experimenting with in-home care of ventilator-dependent children who might otherwise require hospital care during their entire childhood. A multi-agency effort with private sector involvement is intended to provide 24-hour nursing care at home for extended periods. The model is considered conducive to normal child development and is cost effective.

DEVELOPMENTALLY DISABLED

In 1985 the Department of Mental Health & Developmental Disabilities reported fewer than 5,000 developmentally disabled persons of all ages in state facilities. The most prevalent disability is mental retardation but autism, cerebral palsy and epilepsy are included. The disability must originate before the age of 18, be expected to continue indefinitely and constitute a substantial handicap.

The DMH/DD and the Department of Public Aid served 16,000 developmentally disabled persons of all ages in residential care and 17,000 in community day programs in 1985. Community residential facilities range from continuous care in a skilled nursing facility to a home-like environment in which one or two persons reside with live-in staff who care for them as would a family.

In 1983 there were 24,310 educable mentally handicapped (EMH) in the public schools, 37 in private day schools, 8 in private in-state residential and 5 in out-of-state placements. Of the trainable mentally handicapped (TMH) 7,389 were in public schools, 1,846 in private day schools, 763 in private in-state residential and 38 in out-of-state placements.

Interventions for developmentally disabled infants are provided by the Division of Services to Crippled Children, the Departments of Children & Family Services, Public Aid, Public Health, and Mental Health & Developmental Disabilities. These efforts often are not well coordinated. Timely intervention can prevent further disabilities. The Department of Mental Health & Developmental Disabilities will attempt to reduce the waiting list for services to children from birth to three.

At the other end of the age spectrum, the DMH DD will identify programs for persons graduating from special education at age 22 and will work with the Department of Rehabilitation Services for supported employment services to disabled young adults.

The Governor's Planning Council on Developmental Disabilities, required by federal legislation, is responsible for developing and monitoring the State Plan for services to the developmentally disabled.

The Guardian & Advocacy Commission provides legal advocacy to persons who seek protection of rights guaranteed by law, represents individuals in commitment or transfer proceedings and examines allegations of inappropriate treatment. A separate not-for-profit agency, the Developmental Disability Protection & Advocacy Board, will come into existence by 1986.

FUNDING

Quality of health is tied to socioeconomic status more than to any other factor. Private physicians, private hospitals and private health insurance have been a mainstay of the health system. However, when more people are unemployed, fewer are covered by insurance. Medical assistance provides essential care for persons determined eligible by the Department of Public Aid (DPA). Aid to Families with Dependent Children (AFDC) clients are eligible for assistance under Medicaid (Title XIX of the Social Security Act). The Medicheck program for early and periodic screening is part of Medicaid. Other clients whose incomes are slightly higher may be eligible for the Medical Assistance No-grant (MANG) program or Aid to the Medically Indigent (AMI). Medicaid clients may go to health care providers including private physicians and in some areas HMOs, and the provider will be reimbursed by DPA. Many private physicians do not treat public aid patients, citing low fees, delays in payment and the amount of paperwork.

REFERRAL SOURCES

Department of Mental Health & Developmental Disabilities
Springfield: 217-782-2243
Chicago: 312-793-2735

Department of Public Aid
800-252-8635

Department of Public Health
Springfield: 217-782-4977
Chicago: 312-793-2793

University of Illinois, Division of Services to Crippled Children
312-996-3550

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67 E. Madison Street, Chicago, Illinois 60603

Who Cares for Kids?
THE JUVENILE COURT

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

With the passage of the Family Court Act in 1899, Illinois established the first court specifically dealing with juveniles. The court was given authority to intervene in the lives of children who were alleged to be offenders (that is, delinquents) and those who were believed to be victims (that is, neglected or dependent).

As increasing numbers of children passed through the juvenile court system during the first half of the twentieth century, changes were made. Certain procedures and rights which were at first thought unnecessary because the court would act "in the place of the parents" were in fact needed. The Juvenile Court Act of 1965 added due process rights for children and their families and also removed from the category of delinquent, those youngsters who were truant, runaway or ungovernable at home. This kind of misbehavior, referred to as a status offense, is not criminal and is an offense only because of the minor's age, that is, the minor's status. A more recent change requires that attempts be made to work out the problems of the minor with the family before the court may intervene; this has reduced the number of status offenders brought to court. On the other end of the scale, changes in the Act provide harsher penalties for juveniles charged with very serious or repeat offenses.

PURPOSES

The purposes of the Juvenile Court Act are:

- to secure for the child such care and guidance, preferable in his/her own home, as will serve the moral, emotional, mental and physical welfare of the minor and the best interests of the community;
- to preserve and strengthen the minor's family ties whenever possible, removing him/her from the custody of parents only when the minor's welfare or safety or the protection of the public cannot be adequately safeguarded without removal; and
- to secure for the minor removed from the family, the custody, care and discipline equivalent to that which should be given by parents and, in appropriate cases, to place the minor in a family home so that the child can become a member of a family by legal adoption or otherwise.

TERMINOLOGY AND RIGHTS OF JUVENILES

The juvenile court is part of the Illinois circuit court system. The terminology used reflects civil rather than criminal law. For example, matters are initiated in the juvenile court by *petition*, rather than indictment or information; the term *respondent* is used instead of defendant; and the state must prove charges at an *adjudicatory* hearing, not a trial. Certain legal procedures required for criminal proceedings are not applicable. For example, a minor does not have the right to a jury trial unless prosecuted as a Habitual Juvenile Offender. At the same time special procedures protect the juevenile's identity. These procedures include the separation of juvenile law enforcement records from adult records, the restriction of juvenile records to authorized persons and proceedings which are not open to the general public.

The Illinois Juvenile Court Act provides juveniles the rights to be present, to be heard, to present evidence, to cross-examine witnesses, to examine court files and records, to be represented by a lawyer, to appeal the court's decision to a higher court and to be informed of all these rights.

PROCEEDINGS IN JUVENILE COURT

Proceedings may be instituted under the provision of the Juvenile Court Act if a boy or girl is a

- Delinquent minor — one who, prior to his/her 17th birthday, has violated or attempted to violate any federal or state law or municipal ordinance. However, a juvenile 13 years of age or older charged with delinquency may be tried under criminal proceedings either at the minor's request or after a transfer hearing. Juveniles 15 years of age or older charged with murder, aggravated criminal sexual assault or armed robbery with a firearm are automatically tried under criminal proceedings.
- Minor requiring authoritative intervention (MRAI) — one under 18 who is absent from home without permission (runaway) or beyond control of parent or guardian and who, 21 days after being taken into limited custody and having been offered interim crisis intervention services, refuses to return home, and the parents and the minor cannot agree to an alternative voluntary residential placement.
- Addicted minor — one who is an addict as defined in the Alcoholism and Substance Abuse Act or an alcoholic as defined in the Alcoholism and Intoxification Treatment Act.
- Neglected or abused minor — one under 18 who is not receiving proper support, education, medical or other attention necessary for the minor's well-being or who is abandoned. An abused minor is one under 18 who has been physically or sexually abused, is at risk or such abuse or is in an environment injurious to the minor's welfare.
- Dependent minor — one under 18 who is without a parent, guardian or legal custodian or who is without proper care because of the disability of a parent or guardian, or who is not receiving medical or other care through no fault of the parent, or whose parent or guardian wishes to be relieved of parental rights and responsibilities. Cases involving juveniles charged with traffic, boating, fish and game law violations may be prosecuted either in juvenile or another court. Generally, the nature of the offense will determine which court will hear the case.

CUSTODY

A law enforcement officer may take into limited custody for up to six hours any minor believed to be a runaway or beyond the control of parents and in dangerous circumstances. During that time the officer will try to notify the parents and to return the child to the home. If that is not possible, the minor will be referred or taken to an agency providing crisis intervention services.

When a law enforcement officer takes a child into custody, other than for limited custody, the officer must try to reach the parents immediately and must take the child to the nearest juvenile officer. The juvenile officer may give the child a verbal warning; make a station adjustment; release the minor to a parent or other responsible adult which may include referral to community services; release the minor to

parents and referral to a juvenile probation officer; or decide that a formal petition citing charges should be filed with the court. Although any person may file a petition, it is important to note that the state's attorney has the sole authority for proceeding with a case, including dependency and neglect, where protection rather than prosecution of the minor is the issue.

HEARINGS

Juveniles petitioned to court and placed outside their homes must promptly receive a *shelter* or *detention* hearing. The purpose of the hearing is to allow the judge to determine whether there is probable cause to believe that the offense was committed and that the person named in the petition was responsible for the act. The minor will be released to await further proceedings at home unless it is a matter of immediate and urgent necessity to hold the minor in custody or the minor is likely to flee the court's jurisdiction. Children who are placed outside the home have priority in the scheduling of cases. These time frames are much shorter than in criminal trials. Only minors charged with delinquent behavior may be held in detention (a secure facility); and the court must first consider the offense, the minor's delinquency record and record of willful failure to appear in court. Juveniles under 16 confined in a jail must be kept separate from the sight and sound of adults. Sixteen-year-olds may not be kept in the same cell or yard with adult prisoners.

Under certain circumstances, and if all parties agree, the court may grant a "continuance under supervision" known as a 4-7 supervision. An adjudicatory hearing may be held later if the minor fails to follow the conditions of supervision. Minors charged with delinquencies may be ordered to make restitution, to attend school or to undergo treatment, for example. In cases of delinquency, addictions or MRAI, the juvenile will either "admit" the charges (similar to a guilty plea) or "deny" (similar to a not guilty plea). If the minor admits, there is no need for an *adjudicatory* hearing—equivalent of a trial—and the judge will set a date for the dispositional hearing. If the minor denies the charges, the state's attorney will present the charges, witnesses may be called and evidence offered at the adjudicatory hearing. The procedures and terminology are the same in neglect and dependency cases except that it is the parent or other adult who must admit of deny the charges in the petition.

After testimony and evidence are presented, the judge decides whether or not the charges in the petition have been proved by a preponderance of the evidence or, in the case of a delinquent, beyond all reasonable doubt. If the charges are not proved, the petition is dismissed. If proved, the case moves to a *dispositional* hearing to determine what course of action will be in the best interests of both the minor and the community. The judge may ask for a social investigation to assist in making that determination; however, it is required only when a minor is committed to the Department of Corrections. The judge may hear recommendations from the parents or guardian, the child's attorney, the state's attorney, probation officers, social workers or others involved in the case.

DISPOSITIONS

The judge may order any of the following:

- Placement outside the home — If the judge decides that it is not best for the minor to remain at home or that efforts at family preservation or reunification have been unsuccessful, the judge may order that the juvenile be committed to an agency or to the Department of Children & Family Services for care or placement.
- Treatment — A minor who is an addict may be ordered admitted for residential or out-patient treatment by the Department of Alcoholism & Substance Abuse.
- Supervision — A juvenile found to be addicted or an MRAI may be placed under supervision and required to follow certain orders.

If a juvenile has been found delinquent, the judge may select any of the three following dispositions in addition to placement or treatment:

- Probation/conditional discharge — The judge may order the juvenile to make restitution, to perform community service or to attend a residential or non-residential program. If the youth fails to comply, the court may revoke probation and commit the youth to the Department of Corrections. Conditional discharge differs from probation in that the minor is not placed under the supervision of a probation officer.
- Detention — The judge may order that the juvenile be detained up to 30 days in a physically restricting facility, that is, a juvenile detention home or a county jail.
- Department of Corrections — A juvenile 13 years of age or older may be committed to the Juvenile Division of the Department of Corrections if a term of incarceration is permitted for adults found guilty of the same offense.

As dispositional orders may continue until the minor is 21, often it is necessary to hold hearings to review the status of a case, to determine whether the ordered disposition is being carried out or to respond to a request by a juvenile, parent, guardian, probation officer or case worker for a change of disposition.

GUARDIANSHIP AND PARENTAL RIGHTS

The Juvenile Court Act specifies rules and regulations for placement of minors outside the home and the responsibilities of guardianship or custodianship. The guardian or custodian may be required to report to the court at any time and must file updated case plans every six months. When a guardian or legal custodian is appointed, parents retain certain rights and responsibilities. These rights include the right to reasonable visitation with the child, the right to determine the child's religious affiliation, the responsibility for the child's financial support if required by the court and the right to consent to the child's adoption.

Adoption. When the child is to be freed for adoption, the court will hold a hearing to terminate parental rights. If the parent voluntarily gives up the child or if the court finds the parent is unfit on grounds established in the Adoption Act and if it is in the best interest of the child, the judge will order appointment of a guardian with power to consent to adoption. Such an order terminates all parental rights and responsibilities. Because severing the parent-child relationship is such a serious matter, unfitness must be proved by clear and convincing evidence.

PROBATION SERVICES

The Juvenile Court Act requires that the chief judge of each circuit make provision for probation services for each county in the circuit. Probation officers have a wide range of responsibilities involving all children who come before the court, not just delinquents. Duties specified in the Act include the investigation of complaints to assist in determining whether petitions should be filed or the case referred to an agency, conducting pre-hearing investigations and making recommendations to the court, counseling and supervising minors, serving as liaison officers between the court and referral agencies, arranging the court-ordered placements, providing probation supervision and protective supervision and administering court-operated detention facilities.

REFERRAL SOURCE

Illinois Collaboration on Youth Hotline
1-800-252-8045

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67 E. Madison Street, Chicago, Illinois 60603

Who Cares for Kids?
JUVENILE JUSTICE
Courts and Corrections

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

In Illinois persons under the age of 17 who are charged with crimes are usually handled under the Juvenile Court Act. Only 15 and 16 year olds who are accused of murder, aggravated criminal sexual assault or armed robbery with a firearm are automatically prosecuted as adults. A minor 13 or older may be tried as an adult under criminal proceedings at the minor's request or by order of the juvenile court after a transfer hearing.

Juvenile court terminology reflects civil rather than criminal law. Matters are initiated by petition rather than indictment or information. The term respondent is used instead of defendant, and the state must prove charges at an adjudicatory hearing, not a trial. A minor is found delinquent rather than guilty, and receives a disposition, not a sentence.

In 1983, 36,283 juveniles under 17, predominately males, were arrested in Illinois for eight offenses measured by the Federal Bureau of Investigation Uniform Crime Reports. Arrests for violent crimes—murder, rape, aggravated assault and robbery — dropped to 3,573 from 4,185 in 1980. Arrests for property offenses — burglary, larceny/theft, motor vehicle theft and arson — dropped to 32,710 from 36,599 in 1980. In 1983 there were 19,863 delinquency petitions filed in juvenile court, excluding traffic, boating and fish and game law violations.

PREVENTION/EARLY INTERVENTION

The goal of legislation (SB 1500) implemented early in 1985 is to assure that adolescents who come into contact with the child welfare or juvenile justice systems, or who are at risk of doing so, have access to needed prevention, intervention or treatment resources. Central to the legislation is the responsibility of the community to develop an annual plan based on local needs. The Department of Children & Family Services, through the Division of Youth and Community Services, is the funding and monitoring agency. SB 1500 emphasizes the use of local volunteers to correct conditions contributing to delinquency. The Chicago Area Project, in existence since 1934, depends on community autonomy and use of existing institutions in the development of neighborhood delinquency prevention programs. The East St. Louis Performance Ensemble and the Jesse White Tumbling Team (Chicago) are two examples of positive group activities in neighborhoods where there is an abundance of youthful energy but few opportunities to build skills and self-esteem.

An example of a program targeted to a younger group is an effort by Youth Guidance, in conjunction with a neighborhood organization, offering 24-hour response to police referrals and a full range of services to eight-to-twelve-year old delinquents from the Cabrini-Green public housing area in Chicago.

JUVENILE COURTS

Juveniles who come to the attention of the courts may be ordered to undergo medical, mental health or substance abuse treatment, to attend school, to make restitution, to perform service work or to pay costs. In 1983 the courts placed 6,249 juveniles on probation and collected over $250,000 in restitution from nearly 2,000 juveniles.

The organization of probation services ranges from part-time officers in rural areas who work with both adult and juvenile probationers to the Cook County Department of Court Services, which is administered separately from the adult system. Unevenness in the level of probation services has been reduced through state subsidies for county juvenile probation officers and by recruiting and training standards set by the Administrative Office of the Illinois Courts (AOIC). Legislation enacted in 1983 provides full reimbursement for certain personnel, requires participating departments to prepare probation plans for approval of the AOIC and authorizes intensive probation services (IPS) units. Initially, this legislation is expected to have the greatest impact on the adult system.

The first juvenile IPS unit was established in Cook County early in 1985 for probationers with no history of violent behavior or severe psychological disturbance and for whom commitment to the Department of Corrections (DOC) was under consideration. The unit consists of a supervisor and three teams of two probation officers, each team having a maximum caseload of 25. Frequent contacts at any time of the day or night ensure compliance with the strict demands of the program.

Considerable disparity exists among counties in the level of services available for probationers and the financial resources available to the courts to pay for them. Two intensive community programs that have existed for over a decade are the Macon County Day Probation and the Unified Delinquency Intervention Services (UDIS). The Macon County program provides full-time school and social services to probationers in the Decatur area. The nationally-acclaimed UDIS program, administered through the Department of Children & Family Services, relies on contractual services for youths who are referred to UDIS as a condition of probation.

Detention. Juveniles who are charged with delinquent acts remain at home while their cases are pending unless the court orders the minor sheltered, which may be in the home of a relative, a foster home or a group home or, if circumstances require, detained in a secure facility. In 1983, 12,433 juveniles were held in detention facilities and 1,563 in county jails; 10 percent were detained for up to 30 days as a disposition.

The Cook County Juvenile Temporary Detention Center (formerly the Audy Home), with a capacity of 432, is administered by the Cook County Board of Commissioners. The Center is the only juvenile detention facility in Illinois to be accredited by the American Correctional Association. Detention facilities in Adams, Champaign, DuPage, Kane, Knox, Lake, LaSalle, Madison, Peoria, St. Clair, Sangamon and Winnebago Counties, with a combined capacity of 232, are operated by the courts. Other counties rely on alternatives, contract for detention space or place juveniles in county jails. Juveniles under the age of 16 must be separated from the sight and sound of adults. Sixteen-year-olds must not be kept in a cell or yard with confined adults. Illinois's participation in federal Juvenile Justice and Delinquency Prevention funding will necessitate 75 percent compliance with requirements for removal of juveniles from jails by October, 1985, and full compliance by 1988. DCFS monitors compliance; DOC is the regulatory agency for lockups, jails and detention facilities.

THE DEPARTMENT OF CORRECTIONS

A juvenile may be committed to the Department of Corrections (DOC) only for an offense for which an adult may be in-

carcerated. The Juvenile Division, established as a separate division when the Department was created in 1970, must accept all youth 13 years and older committed by the courts. In 1984, 700 were committed as delinquent under juveile proceedings and 66 as felons under criminal proceedings. A few of the felons have sentences of natural life. At their 17th birthday, felons return to the committing court for a judicial determination as to whether they should be moved to the Adult Division.

Medical, psychological, social, educational, vocational and offense histories are assessed at reception — one unit for males and one for females — to determine each youth's risk level and special needs. Males are assigned to one of seven youth centers; females are placed at the single co-ed facility.

Seventy percent of the Juvenile Division population is 15-to-17 years of age. Forty percent have an achievement level of sixth grade or less, with eight percent performing at an academic level of grades one-to-three. The Department has its own school district which provides elementary and secondary education, remedial, special and vocational education. Participation is required. The school district contracts with community colleges for hands-on vocational programs, including building maintenance, food services and small appliance repair.

The female juvenile population comprises 5 percent of the total DOC population. Some have committed very serious offenses, others have had multiple contacts with the welfare, justice or mental health systems. Some are mothers; others may be pregnant. These young women are difficult to place once they are released.

The courts have determined that committed persons have a constitutional right to medical care. The Department contracts for physicians, related health services and hospital care, including obstetrical services for high risk pregnancies. An increasing number of committed youths have identifiable mental health conditions including neurological damage, affective disorders, psychoses and history of prior psychiatric hospitalization. The Department has established three non-hospital treatment units to provide services to 76 disturbed youths.

A delinquent is committed for an indefinite term. A service plan is written and a projected release date set at the beginning of the youth's stay. The decision to release (parole) delinquents for supervision in the community is made by the Prisoner Review Board after a youth's appearance at a hearing. Habitual Juvenile Offenders and felons, on the other hand, have their sentences set by the court, with the right to earn time for good conduct.

Planning for the youth's return to the community is initiated shortly after commitment. The Department's juvenile parole agent visits the institution, serves as liaison to the youth's family and updates the youth's service plan as necessary. Parolees tend to be older, have few skills and are unlikely to return to school. Some need intensive mental health or other services.

The decision to discharge youth from supervision is shared by the juvenile court, the Prisoner Review Board and the Department of Corrections. Parolees who do not follow orders for community supervision may be returned to the Juvenile Division; however, no juvenile court disposition may continue after the youth reaches 21.

Provisions of the Interstate Compact on Juveniles, administered by the Administrative Office of the Illinois Courts and the Department of Corrections, apply to probationers and parolees who are sent to or received from other states.

Illinois Department of Corrections
Juvenile Division • March 31, 1985
Total Population 2,487

Profile	
Illinois Youth Center population	57%
Parole supervision population	43%
Commitments from Cook County	63%
Commitments from other counties	37%
Males	96%
Females	4%
Race: Black	59%
White	31%
Hispanic	8%
American Indian	1%
Delinquents	84.4%
Habitual Juvenile Offenders	8.9%
Court Evaluations	5.8%
Habitual Juvenile Offenders	.8%

All juvenile facilities and programs meet or are in the process of meeting standards of the American Correctional Association.

FUNDING

The federal Juvenile Justice & Delinquency Prevention Act of 1974 brought funding into Illinois for the removal of status offenders from detention, the removal of juveniles from jail and, more recently, for community programs to address serious offenders and youth gang activities. The Department of Children & Family Services is the designated agency and is assisted by the Juvenile Justice Commission.

The Illinois Criminal Justice Information Authority (CJIA) has been designated to administer the Victims of Crime Act (VCA) of 1984 and the Justice Assistance Act (JAA) of 1984. The JAA funds will focus on community crime prevention, information system improvement, identification and prosecution of serious repeat offenders (including juveniles) and training of criminal justice personnel.

REFERRAL SERVICES

Illinois Criminal Justice Information Authority
120 South Riverside Plaza, Chicago, 60606,
312-793-8550

Gang Crime Information: 312-744-GANG.
Cook County gang prosecution hotline 312-890-3454.

Department of Corrections
1301 Concordia Court, Springfield 62702
217-522-2666.

Department of Children & Family Services, Division of Youth and Community Services,
One North Old State Capitol Plaza, Springfield 62706.
217-785-2509.

Administrative Office of the Illinois Courts,
413 West Monroe
Springfield, Ill. 62704
217-785-0413.

Office of Advocacy Services
Department of Corrections
58 North Chicago Street
Joliet, Ill. 60431
815-726-6114.

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67 E. Madison Street, Chicago, Illinois 60603

Who Cares for Kids?
MENTAL HEALTH & EMOTIONALLY DISTURBED CHILDREN

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

In *Unclaimed Children* the Children's Defense Fund (CDF) reported in 1982 that two-thirds of the nation's seriously disturbed children did not get the care they needed and countless others received inappropriate care. Less than half of the states surveyed by CDF had a special children's unit within their mental health department, only one-third could track all or part of their expenditures for children and only a handful of states were making efforts to create a system of care or to have welfare, juvenile justice and education work together on behalf of disturbed children and adolescents for whom they all have some responsibility. In other words, these children were unclaimed by the public agencies with responsibility to serve them.

In Illinois several state departments are required to serve children and adolescents who are mentally ill, emotionally disturbed or behaviorally disordered. These terms are sometimes used interchangeably so that programs serving these children may lack clarity.

ILLINOIS STATE SERVICES FOR MENTALLY ILL AND EMOTIONALLY DISTURBED CHILDREN

The Department of Mental Health & Developmental Disabilities. Illinois Juvenile Research has responsibility for all DMH/DD Child & Adolescent (C&A) clients hospitalized in the Chicago area metro regions. IJR statewide C&A services office has responsibility for planning, coordinating and establishing standards and priorities for all state-operated C&A programs as well as for those funded through state grants.

The Department assists parents in the placement of their children through Individual Care Grants (ICGs). A December 1984 census showed 94 ICG's, with 24 children place in out-of-state facilities. The Department supports community programs that provide outpatient therapy and day treatment for children and adolescents and the Department purchases care in private psychiatric hospitals.

The Department operates 300 hospital beds for mentally ill or emotionally disturbed children and adolescents. Children 12 and younger are separated from adolescents who in turn are separated from adults 18 or older. These programs are accredited by the Joint Commission on the Accredition of Hospitals.

A minor may be admitted after a finding by the facility director that the minor has a mental illness or emotional disturbance of such severity that hospitalization is necessary and that the minor is likely to benefit from inpatient treatment. In 1983 there were 988 child and adolescent hospital admissions; one-third were rehospitalizations.

Under the Mental Health & Developmental Disabilities Code, a minor 14 or older has the right to request and receive outpatient counseling services or psychotherapy and a minor 16 or older has the right to be admitted for hospitalization as a voluntary patient. The Code requires that hospitalization be reviewed periodically and provides for court hearings. The minor has the right to appointed counsel.

The Illinois State Board of Education. The federal Education for All Handicapped Children Act of 1975 (PL 94-142) plays an important role in providing funding for disturbed young people under the designation behavior disordered. In 1983 there were 18,188 behavior disordered children served in the public schools, 2,019 in private day schools, 316 in private in-state residential facilities and 219 in private out-of-state facilities. Reimbursements for educational programs and residential care are made to the local district by ISBE after approval by the Governor's Purchased Care Review Board. Certain services are co-funded by the Department of Mental Health & Developmental Disabilities. An increasing number of behavior disordered children and adolescents are served by ISBE and an increasing number are placed in residential care.

Juvenile Courts. Where children enter the system is often determined by the juvenile courts. The levels of diagnostic services available range from the informal to Cook County where the juvenile court's Psychiatric Department is required by law. A child's mental health history is part of a social investigation; however, investigations are mandatory only for youth committed to the Department of Corrections.

The Department of Children & Family Services. Children in the care of DCFS frequently have emotional problems or come from dysfunctional homes where they have been victimized by abusive, neglectful or disturbed families. The Department may offer supportive services to the family, place a problem child in a specialized foster family home, contract for private residential services or provide financial assistance to facilitate the adoption of a child with emotional handicaps.

The Department of Corrections. Medical, psychological, social and offense histories are assessed at the time of the youth's commitment. An increasing number of youth have identifiable mental health conditions, including neurological damage, affective disorders, psychoses and history of prior psychiatric hospitalization. The Department has established three non-hospital treatment units to provide services to 76 disturbed youths. The Department is authorized to transfer youths to the Department of Mental Health & Disabilities. However, aggressive behavior frequently serves as a barrier to hospitalization.

The Guardian & Advocacy Commission, a state agency established in 1979, provides legal advocacy to persons with mental disabilities who seek protection of rights guaranteed by law, represents individuals in commitment or transfer proceedings and examines allegations of inappropriate treatment.

BARRIERS TO SERVICE

Since many state departments provide services for disturbed children and mandates differ for each, fragmentation of services may be a problem. Fragmentation has not been conducive to the development of a cohesive system. Children and adolescents with serious and aggravated problems who need services from a variety of agencies generally are underserved. Where the child enters the care system can determine how problems are perceived and what services are delivered. Once responsibility of a given system has been established, it can be difficult to shift and receive services from one department

or system to another. Departmental disputes and unwillingness to serve children who are believed to be another department's responsibility are not uncommon. Some of these children require costly treatment, resulting in a reluctance among agencies to serve them.

Community-based services for mentally ill, emotionally disturbed and behaviorally disordered children and adolescents tend to vary from community to community both in terms of range of services available and service eligibility criteria. A comprehensive plan for state services does not exist. A March, 1985, report by the Illinois Commission on Mental Health & Developmental Disabilities identified prevention/early intervention, diagnostic/assessment, crisis/emergency/respite care, residential placement, intensive treatment and aftercare as critical elements needed in a comprehensive plan.

There is no statutory requirement for preventive services. Frequently problems escalate to the point where more costly, restrictive services become necessary. There is no system of assessment common to all child-serving agencies. This has hampered efforts to identify the number of severly disturbed young people and to determine whether or not they are appropriately served or what services are needed. Child welfare facilities report an increasing number of disturbed youngsters in their care. Specialized treatment facilities are relatively few; often one child must be moved before another can be admitted.

FUNDING

Very little medical insurance exists for the types of services most needed by severely emotionally disturbed young people. Title XIX of the Social Security Act (Medicaid), administered by the Department of Public Aid, is considered inadequate since many facilities in the private sector do not accept Medicaid clients. The federal Alcohol, Drug and Mental Health Block Grant, unlike the acts it replaced, does not earmark any funds specifically toward children and adolescents. Illinois, as is true in many states, is highly dependent on funding from PL 94-142, administered by the Illinois State Board of Education, for services to disturbed children and adolescents.

BUILDING A SYSTEM

Despite the present piecemeal system of serving disturbed children, some promising cooperative efforts have emerged.

- The Tri Agency program (Chicago) administered by the C&A Office, serves 15 DMH/DD and DCFS adolescents in long-term hospital care. This program has been in existence since 1970. A newer non-hospital unit at an Illinois Youth Center serves DOC youth. The programs are jointly funded by the three agencies.
- The Governor's Youth Services Initiative (GYSI), with the DCFS as lead agency, grew out of a Cook County lawsuit. It is a process available to the juvenile courts for resolving disputes over the type of service a child should receive and which agency should be responsible.
- Legislation (SB 1500) is expected to encourage linkages between systems. In some cases the local youth service board recognized by the Department of Children & Family Services is closely related to the community's mental health agency. Mental health representatives must also be included at the regional level in the local service plan review process.
- The Children's Policy Group, composed of representatives from the major child-serving agencies, was organized in 1984 to assist the Governor's Human Services Subcabinet by identifying and making recommendations of interagency concern related to policies and services to children and adolescents. First-year efforts of the Group led to a liaison between DMH/DD and DCFS to address interagency issues on a regional basis, a mental health/child welfare task force with participation by ISBE, an interagency agreement between DMH/DD and DCFS for joint programming and a joint $3.4 million 18-month demonstration program. One component is targeted toward the identification of children nine years or younger who are at risk for future services in more restrictive settings.

The Department of Mental Health & Development Disabilities Child and Adolescent objectives for 1986 include the development of a long-range plan, a tracking mechanism to identify unserved and underserved populations and a focus on specialized populations such as DCFS wards and DOC recipients.

DMH/DD in conjunction with DCFS has applied for grant for a Child & Adolescent Service System Program (CASSP) in Illinois. The goal of CASSP is to assist states and communities in establishing a comprehensive and coordinated system of care for severely emotionally and mentally disturbed children and adolescents. In several states CASSP assistance resulted from a class action suit or threat of litigation.

These efforts signal the possibility of a step forward in dealing with the whole child and the whole problem.

REFERRAL SOURCES

Department of Mental Health & Developmental Disabilities
Springfield: 217-782-2243
Chicago: 312-793-2735

Institute for Juvenile Research
1735 W. Taylor
Chicago, Illinois
312-996-1000

Illinois Institute for Developmental Disabilities
1640 W. Roosevelt Road
Chicago, Illinois
312-996-1000

Illinois State Physciatric Institute
1601 W. Taylor
Chicago, Illinois
996-1000

(See also list of referral sources in overview)

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Who Cares for Kids?
PERMANENCY PLANNING
Reunification, Foster Care and Adoption

LEAGUE WOMEN VOTERS OF ILLINOIS EDUCATION FUND

Although the state agencies providing care for children have stated that such care is best provided when a child remains in the home, sometimes that is not possible. If necessary for a child's welfare, or if efforts to provide needed services to a child living at home are not successful, a child may be placed in substitute care in a relative's home, a group home, a foster home or an institution. Permanency planning is the effort to ensure that a child who enters the substitute care system has a stable, continuing relationship with nurturing parents without the multiple moves that many children experience when they are placed in foster care.

Despite the ideal expressed in the Family Court Act of 1899, "to place the minor in a family home so that he may become a member of the family by legal adoption or otherwise," at the end of July, 1979, the Department of Children & Family Services (DCFS) reported 11,489 children in substitute care in Illinois. The children had an average length-of-stay of almost four years, with more than one-fifth of the children having been moved four or more times.

THE ADOPTION ASSISTANCE & CHILD WELFARE ACT

In 1978 in "Children Without Homes" the Children's Defense Fund reported a widespread lack of family support programs to prevent a child's removal, a lack of reunification efforts, a lack of standards for substitute care and a lack of fiscal incentives for keeping children in their homes. Often there was no system for keeping track of where children actually were. These were some of the conditions that led to the passage of the federal Adoption Assistance and Child Welfare Act of 1980 (PL 96-272), which has had a major impact on child welfare services in Illinois.

Public Law 96-272 requires that in order to receive funding for child welfare services a state must do the following:

- provide pre-placement prevention services;
- have a reunification program designed to facilitate the return of children to their families;
- have written and documented case plans specifying what services will be provided for each child in out-of-home care; and
- hold administrative case reviews at least every six months and court reviews at least every 18 months to review permanency plans.

States must also provide foster care and adoption assistance programs.

The Department of Children & Family Services is responsible for implementing the provisions of PL-96-272. A major tool in permanency planning is the Child and Youth-Centered Information System, a computerized case recording system that enables the Department to track children in foster care or under juvenile court jurisdiction. Under the Interstate Compact on the Placement of Children, the Department also supervises 244 Illinois children placed out-of-state as well as children from other states who live in Illinois. Prior to Illinois's joining the Compact a decade ago, over a thousand children were reportedly placed in out-of-state facilities. The Department, as regulatory and licensing agency for all child care facilities in Illinois, is responsible for the quality of out-of-home care.

FOSTER CARE

The largest number of children in subsitute care are in foster family homes—the placement of a child with a family other than the child's own for an indeterminate period of time. Most children in foster care are dependent, neglected or abused, but the court may order foster care for any child for whom such placement is considered appropriate.

There is always a need for more foster homes, particularly homes for teenagers, disabled children or sibling groups. Single adults may become foster parents. Prospective foster parents may indicate the age, sex and type of child they believe would be appropriate. After screening and an interview, adults may be licensed as foster parents and may receive a stipend to cover the foster children's room and board. Usually supportive services are offered to foster children, the birth parent and foster parents. Opportunities are arranged for foster children to visit their birth parents on a regular basis. Foster parents may have contracts with the DCFS or with one of the licensed child welfare agencies in the state that recruit and supervise foster parents.

Family Preservation The Department offers such pre-placement services as emergency caretakers, counseling, day care, crisis intervention and job training so that children can remain at home. When a child is removed from home, reunification services are made available so that a child will either be returned home in a timely manner or remain in a stable long-term foster home. Caseworkers develop a service plan signed by the parents, specifying any changes needed before the parents may regain custody of their children. Once visitation of the parent with the child is arranged, the visits are evaluated. The Department considers the parent-child visits especially important and one of the clearest indicators of parental interest in a child.

In certain cases reunification services may be inappropriate or unsuccessful. In addition, for an older adolescent who does not wish to be adopted, independence may become the permanency goal. If over a period of time the parents fail to fulfill the goals established by the agency and the parents, and if no progress is being made, the Department may request that the state's attorney file a petition in the juvenile court asking that parental rights be terminated. Specific procedures vary from county to county.

Termination of Parental Rights There are 16 grounds for involuntary termination of parental rights. Among them are abandonment, extreme cruelty, failure to protect the child and substantial neglect. Changes in the law in 1981 established failure of a parent to visit or communicate with a child for one year as grounds for a finding of unfitness, shifted the primary responsibility for visiting and maintaining contact with a child from the social service agency to the parent, eliminated the requirement that the adoptive parent be identified prior to legal termination of rights of an unfit parent and gave foster parents who have cared for a child continuously for 12 months preference if the child becomes free for adoption. The U.S. Supreme Court has raised the standard of proof of an unfit parent to "clear and convincing" from the less strict "preponderance of the evidence." An earlier Supreme Court decision gave the birth father certain rights in regard to his

children.

Birth parents may voluntarily surrender their parental rights. After rights have been terminated, either voluntarily or involuntarily, the court orders appointment of a guardian with right to consent to adoption.

ADOPTION

Barriers that prevent children from being adopted in Illinois include a reluctance on the part of judges to terminate parental rights; the lack of prospective adoptive parents for black children; difficulties in placing white handicapped, retarded or older children; the inability of many prospective adoptive parents to finance the support of an adopted child; and delays in adjudication of neglect/abuse and dependency cases.

Child welfare professionals generally agree that judges are extremely reluctant to terminate parental rights, perceiving these rights as among a parent's most precious. In some cases, however, refusal or reluctance to terminate parental rights may result in a child's remaining in foster care for too long — perhaps an entire childhood — and thus never experiencing a stable, permanent home.

To facilitate adoptions in Illinois, the Department added specialists and attorneys to its staff and funded the Adoption Information Center of Illinois (AICI), administered by the Child Care Association. The AICI helps coordinate publicity efforts on behalf of adoptable children and has a toll-free hotline and a referral service linking prospective parents with adoptable children. The success of *One Church, One Child,* has been copied in other parts of the state. The project is based on the premise that each black church should take responsibility for recruiting at least one black family to adopt a waiting child.

PL 96-272, recognizing that many children remain in substitute care because they are difficult to adopt, provides federal funds to assist in the adoption of children for whom adoption would otherwise be unlikely: children with physical, mental or emotional handicaps, minority children, children six years old and older, children who should be placed with siblings, children who have been in the same foster home for a year or longer and where assistance is needed to complete an adoption.

Despite strides made by the Department in permanency planning, more than 5,000 children have been in care for two years or more and over 2,500 remain in care for five or more years, according to Illinois Action for Foster Children. Fifty-six percent of Illinois children in substitute care reside in the Cook County region, and efforts to place the children in permanent homes are hampered by a large, complex caseload and a lack of resources. The DCFS-operated shelter network in Cook County provides an opportunity for the Department to assess the child's needs and then select the most appropriate placement and to offer supportive services rather than moving the child when problems arise.

Delays in the juvenile court system also hinder timely efforts to reunify families or to seek permanent homes for children awaiting adoption. A Court Appointed Special Advocate program has been proposed for the Cook County Juvenile Court in order to facilitate moving children through the foster care system and into permanent living arrangement as quickly as possible.

FUNDING

DCFS may provide child welfare services through its own resources or may contract for services that include crisis intervention, foster care, counseling, residential treatment, job training and support services. Private agencies may receive partial funding through grants from DCFS or other state agencies.

Several sections of the federal Social Security Act apply to permanency planning goals by providing financial incentives for keeping a child with the family: Title IVE Adoption Assistance and Child Welfare Act, Title IVB Child Welfare Services, Title IVA Aid to Families with Dependent Children, Title XX Social Services Block Grant and Title XIX (Medicaid). Adoption assistance automatically entitles the child to Medicaid coverage, whether or not the adoptive family is eligible.

Adoption subsidy regulations published in November, 1984, appear to be more restrictive. Advocacy groups and child welfare professionals have expressed concern that the new regulations will have an adverse effect on future adoptions.

REFERRAL SERVICES

Several groups advocate for improved services to children in the child welfare system. The Illinois Action for Foster Children, a statewide coalition of public, private and voluntary agencies, foster and adoptive parents and concerned citizen advocates promotes improved services to foster and adoptive children. The Illinois Foster Parents Association lends support to foster parents and provides liaison between foster parents and DCFS. The Illinois Council on Adoptable Children, a statewide organization, provides pre-adoption and post-adoption services to families. The Coalition for Permanent Families for Children promotes expeditious handling of children who are in need of adoption or foster placement in Illinois.

Adoption Information Center of Illinois
800-572-2390

Illinois Action for Foster Children
312-579-0179

Illinois Coalition for Permanent Families for Children
312-392-9255

Illinois Council on Adoptable Children
312-653-2299

Illinois Foster Parents Association
217-673-6021

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Who Cares for Kids?
TEENAGE PREGNANCY AND PARENTHOOD

LEAGUE OF WOMEN VOTERS OF ILLINOIS EDUCATION FUND

Pregnancy among adolescents in this country is a serious problem with tremendous social and economic implications. In Illinois in 1983 approximately 45,000 adolescents became pregnant; nearly 30,000 gave birth. The phenomenon is not limited to Chicago. One-fourth of all Illinois counties have teen birth rates higher than Cook County. Although the overall incidence of adolescent pregnancy is slightly less than in 1970, the rate for young women 15 years of age and under is increasing, paralleling a corresponding increase in early teenage sexual activity. Authorities feel teenagers are reluctant to use contraceptives. The Illinois Department of Public Health (DPH) estimates that 70 percent of teens who seek family planning for the first time do so because they think they are already pregnant.

The costs of adolescent pregnancy to the mother, her child, the family and society are great. Medically the odds for the healthy survival of an adolescent mother and her baby are far from favorable. They are both at very high risk. In Illinois the infant mortality rate for babies born to teenage mothers is 39 percent higher than it is for babies born to all women. The younger the mother, the higher the risk of toxemia, anemia, prolonged labor, premature birth and low birthweight. These medical risks can be greatly reduced with early, comprehensive medical care, but 55 percent of teenage mothers receive no prenatal care in the first trimester.

Education and employment opportunities are impaired for young women who became pregnant. The most common cause of female school dropouts is teen pregnancy. This results in limiting the young woman's opportunity to learn skills and to compete in the job market. Among those who give birth at age 17 or younger, 80 percent never finish high school, and some never even complete the eighth grade. Many girls who do continue in school drop out after delivery because they cannot find adequate, affordable day care. An incomplete education has lifetime implications, including reduced employment possibilities, poor earnings potential and the possibility of dependence on welfare as a major source of income.

Babies born to teenage mothers are more likely to grow up in single parent homes. Sixty-six percent of girls who marry when they are 14 to 17 years of age become separated or divorved. One-third of all single parent families, most of them headed by women, are poor. Sixty percent of households headed by females age 15 to 24 are living below the poverty line. As a result teenage mothers and their babies have a high risk of living in poverty and deteriorated housing with inadequate diets and medical care. A lack of parenting skills and child-rearing experience may cause further problems.

STATE DEPARTMENTAL SERVICES

In the past, services in Illinois have been scattered among a variety of agencies. Interdepartmental cooperation and coordination have been limited. Relatively few programs have been successful in attracting teens to use their services. The four state agencies that have had major program and funding responsibilities for services are the Illinois State Board of Education (ISBE), the Department of Public Aid (DPA), the Department of Children & Family Services (DCFS) and the Department of Public Health (DPH).

The Illinois State Board of Education (ISBE) provides a variety of educational resources related to adolescent parenthood on a local option basis. Services vary depending on the size of the school system, the funds available, the incidence of teenage pregnancy and the community responsiveness to the problem. ISBE strongly encourages, but does not require local districts to institute and maintain appropriate programs in family life and sex education. The content of such courses is determined by the local district. Every five years ISBE conducts a census of course offerings and the number of students enrolled in sex education/family life classes. The last census, for the 1981-82 school year, revealed that there was a significant decline in both the number of schools conducting such courses and the number of students enrolled in them compared to the previous 1976-77 census.

The administration of federal family planning funds coming into Illinois became the responsibility of the Department of Public Health in 1984. In Illinois 71 agencies operate 108 family planning clinics which are closely monitored by the Department. Funding is derived from both public and private sources with most of the money coming from four separate programs: Title X of the Public Health Services Act and Titles V, XIX and XX of the Social Security Act. The remaining public dollars come mainly from the required state match for federal funds. These funds are not limited to the provision of contraceptive devices and medical services. They are also available of education and information programs related to family planning.

The right of a pregnant student to an education has been firmly established, but exercising this right often depends on the motivation and perseverance of the girl and her parents. Pregnant teens in Illinois may remain in the regular classroom, receive education at home or attend an alternative education program if one is available. Programs specifically designed for pregnant teens, apart from the regular high school, are offered in some districts. There are 90 sites throughout the state where students can acquire a General Education Degree (GED). Many of these are used by pregnant teens and young parents returning to school.

There are four sites serving a total of about 750 students which provide alternative education for pregnant teenagers in Chicago. Each has a health clinic within the school staffed by the Chicago Health Department. After delivery the girl may return to her regular school, but there is little followup to see if she does. Other communities offering alternative educational opportunities to pregnant girls include Peoria, Freeport, Rockford, Galesburg, Decatur, Rock Island, Livingston County and the Alexander/Johnson/Massac/Pulaski/Union County region.

The Department of Public Aid (DPA) administers the Aid to Families with Dependent Children (AFDC) program, a federally funded cash assistance program for financially eligible families. In most cases a food stamp bonus is also available. At present, a young mother has the option of remaining on her own mother's grant and adding her infant to the grant or applying for a grant in her own name, whether or not she is living on her own. In August, 1984, DPA reported there were 26,603 teens statewide receiving their own checks, 17,865 of them in Cook County. Through Medicaid (Title XIX) the Department provides medical care for young women and their children receiv-

ing AFDC. Medicaid covers prenatal care, delivery, postpartum, pediatric and contraceptive services, as well as treatment of illness. With a Medicaid card the young mother is entitled to receive care from private doctors, clinics and hospitals, but sometimes medical providers are reluctant to accept Medicaid cards becuase of low state reimbursement rates and delays in receipt of payment. Because of this problem DPA has launched a pilot program in selected areas of the state in which clients are referred to a contracted Health Maintenance Organization (HMO) for medical services.

The Department of Children & Family Services (DCFS) has a program of service for young people about to become parents. Funds are used to contract for counseling and maternity home services from voluntary agencies and to pay for medical care for teens. The Department offers services to its own wards who may be pregnant. It also provides counseling and placement services for young parents wanting to place a child in adoption.

The Department of Public Health (DPH) provides services through a program of grants to local health departments under which basic medical services can be administered. This is not statewide since some counties do not have local health units. The Department does focus on pregnant teens, adolescent parents and their children because they are a high-risk population. Services include family planning, comprehensive prenatal care and programs targeted toward reducing Illinois's high infant mortality rate. The Special Supplemental Food Programs for Women, Infants and Children (WIC), which offers health assessments, nutrition education and food supplements for low-income pregnant women, nursing mothers and children age zero to five, is administered by DPH. It is estimated that 20 percent of WIC recipients are teenage mothers.

COORDINATION OF SERVICES

Services developed over the past ten years have recognized that just providing care during pregnancy does not address the complexity of teenage pregnancies. The goal of many agencies is a coordinated approach: the linking of medical and educational resources, along with social services and child care programs, into a comprehensive system including prevention, care during pregnancy, and support systems after delivery.

In 1977 a volunteer group of concerned individuals and organizations in Illinois joined together as the Illinois Caucus on Teenage Pregnancy; the goals of this group are identifying local service gaps and problems, providing public education about the problem of teenage pregnancy and fostering greater cooperation among private groups and local and state agencies in providing a wide range of programs for at-risk adolescents. In 1980 the Caucus, together with the Conference of Women Legislators, successfully introduced the bill to establish the statewide Task Force on Adolescent Support Services which included representatives of major state agencies serving adolescents. In 1982 the Task Force selected the Caucus as the lead agency to implement its comprehensive plan for coordination of teen services. Funding was provided by DPH.

PARENTS TOO SOON

In the spring of 1983 in response to the problem of teenage pregnancy, Governor Thompson established the Parents Too Soon program. The goals of the program are to reduce the incidence of teenage pregnancy, to improve pregnancy outcomes and to provide appropriate support services. Young people between the ages of 11 and 20 who might become a parent, who are expecting a child or who are already a parent may be eligible for the services of the Parents Too Soon program.

Six state agencies pooled some of their federal funds which they had received through the Emergency Jobs Bill, with DPH as the lead agency. Three demonstration projects have been funded, one on Chicago's west side, one in Winnebago County and another in the southern seven Illinois counties. The demonstration projects bring together all appropriate services to determine how best to meet the needs of teenage parents. Other services of the Parents Too Soon program may including job training, nutrition supplements, medical care, day care, parenting training, family planning, drug and alcohol abuse services and counseling and are available statewide generally through cooperative programs funded in part by local agencies.

The budget for FY 1986* allocated $12,154,700 to fully establish the Parents Too Soon effort for the Departments of Public Health, Public Aid and Children & Family Services. Support and services are also provided by other agencies. Some help is available in many areas through health departments, school districts, day care centers and alcohol and substance abuse centers.

REFERRAL SOURCES

The Illinois Caucus on Teenage Pregnancy has published a directory of teenage pregnancy preventive and supportive services in the Department of Public Health Regions outside Cook County.

Illinois Caucus on Teenage Pregnancy
State of Illinois Center
100 West Randolph
6th Floor, Room 248
Chicago, IL 60601
312-621-0023

Parents Too Soon toll-free hotline
800-572-3270

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67 E. Madison Street, Chicago, Illinois 60603

*FY 1986 refers to the fiscal year which ends in 1986.